

Good**Berkshire Healthcare NHS Foundation Trust**

Child and adolescent mental health wards

Quality Report

Berkshire Adolescent Unit
Wokingham Hospital
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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RWX70	Berkshire Adolescent Unit	Berkshire Adolescent Unit	GR41 2RE

This report describes our judgement of the quality of care provided within this core service by Berkshire Healthcare NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Berkshire Healthcare NHS Foundation Trust and these are brought together to inform our overall judgement of Berkshire Healthcare NHS Foundation Trust.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for the service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Good 

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

Summary of findings

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Summary of findings

Overall summary

We rated child and adolescent mental health wards as **good** overall because:

- Following our inspection in December 2015, we rated the service as good for effective, caring, responsive and well led.
- During this most recent inspection, we found that the service had addressed the issues that had caused us to rate safe as requires improvement following the December 2015 inspection.
- The child and adolescent mental health wards were now meeting Regulations 9 and 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Summary of findings

The five questions we ask about the service and what we found

Are services safe?

We re-rated safe as good because:

- The trust had addressed the issues that had caused us to rate safe as requires improvement following the December 2015 inspection.
- In December 2015 we found that staff had not identified or managed all ligature risks. On this inspection we found the trust ensured they identified and mitigated all ligature risks. Although lines of sight on the unit were poor, and there were static ligature risks throughout, staff ensured they regularly monitored all areas of the unit. The provider had carried out significant works to reduce the risk of ligatures since the last inspection. All staff received training in ligature risks and were clear on how to identify and deal with new risks.
- Staff undertook regular environmental risk assessments and this formed part of the wider unit risk register. These were up to date and reviewed regularly. All staff wore alarms and all rooms on the main unit had nurse call buttons.
- All areas of the unit were clean and staff adhered to infection control principles. The clinic room was clean and tidy and staff regularly checked the equipment and emergency drugs.
- In December 2015, information in risk assessments did not inform care plans. During this most recent inspection, we reviewed five out of nine care records and found clear, detailed and up to date risk assessments in all five. All had a risk management plan that fed into an individualised care plan for each patient. Staff regularly reviewed and up dated patient risk assessments. The provider had ensured that staff undertook a training programme on risk assessment.
- We reviewed eight medicine charts and found these all to be in good order. Staff regularly reviewed all medicines prescribed on an 'as required' basis.
- Staff had good knowledge of safeguarding issues. The trust employed a safeguarding lead who held safeguarding supervision sessions with staff each month. Staff felt confident

Good



Summary of findings

in identifying and reporting safeguarding issues, including historic disclosures of abuse. We reviewed five care records and found that safeguarding risks, where identified, were clearly recorded in the notes.

- Staff reported incidents appropriately and knew what to report. The unit held weekly debriefing meetings where staff discussed and reviewed recent incidents. We reviewed minutes of these meetings and found evidence that the unit implemented learning from incidents. Staff also ensured they debriefed patients following incidents.

However:

- Staffing at the unit remained a concern and there was high use of agency staff. This remained on the unit risk register. However, managers and staff we spoke to all reported staffing levels were improving and were overwhelmingly positive about the new management in place since August 2016. The trust had a robust action plan in place to deal with staffing issues.
- Patients told us they had seen agency staff falling asleep during the night shift. We immediately brought this to the attention of the service manager who was aware of this issue. We were satisfied the trust were dealing with these concerns.
- At the time of our inspection only 69% of staff had completed the prevention and management of violence and aggression (PMVA) training. This was partly due to turnover of staff and the high use of agency staff. The trust recognised this and placed it on the risk register, with an action plan to ensure all staff undertook this training including new staff members and long term agency staff. The trust expected full compliance by February 2017.
- Restraints were recorded appropriately. However one restraint was recorded as being prone restraint. This was not well documented and the length of time of the restraint was unclear. Intra muscular medication was also used in this restraint but was not recorded as rapid tranquilisation. Staff did monitor the patient appropriately following this intervention.

Are services effective?

At the last inspection in December 2015 we rated effective as **good**. Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

Good



Summary of findings

Are services caring?

At the last inspection in December 2015 we rated caring as **good**. Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

Good



Are services responsive to people's needs?

At the last inspection in December 2015 we rated responsive as **good**. Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

Good



Are services well-led?

At the last inspection in December 2015 we rated well led as **good**. Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

Good



Summary of findings

Information about the service

Berkshire adolescent unit is a nine bedded inpatient mental health unit for children and young people. It is the only inpatient child and adolescent unit within Berkshire Healthcare NHS Foundation Trust and takes referrals from Berkshire as well as out of county referrals. The unit is mixed sex and admits children and young people aged 12 to 18. The service provides intensive interventions to facilitate the prevention, diagnosis, management and treatment of severe and enduring mental illness in young people who require hospital admission. The unit can also offer a step down service prior to full discharge for patients attending as a day patient. There were nine patients in the unit at the time of our inspection.

When the CQC inspected the trust in December 2015, we found that the trust had breached regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014. We issued the trust with two requirement notices for child and adolescent mental health wards. These related to the following regulations:

- Regulation 9 HSCA (RA) Regulations 2014 Person centred care
- Regulation 17 HSCA (RA) Regulations 2014 Good governance

Our inspection team

Team Leader: Serena Allen, Inspection manager, Care Quality Commission.

The team that inspected this core service consisted of an inspector, an inspection manager and two specialist advisors, one of whom was a qualified social worker and one a registered mental health nurse.

Why we carried out this inspection

We undertook this inspection to find out whether Berkshire Healthcare NHS Foundation Trust had made improvements to their child and adolescent mental health wards since our last comprehensive inspection of the trust in December 2015.

When we last inspected the trust in December 2015, we rated child and adolescent mental health wards as **good** overall.

We rated the core service as requires improvement for safe and good for effective caring responsive and well led.

Following the December 2015 inspection, we told the trust it must make the following actions to improve child and adolescent mental health wards:

- The provider must ensure that the ligature risk assessment is updated and includes details about how all risks are managed. All staff must know where the ligature risks are, understand how to manage those risks, and improve patient risk assessment when allocating bedrooms.
- The provider must ensure that staff include all risks that they identify, when making a risk assessment of a patient, in the patient's care plan.

These related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

Regulation 9 Person centred care

Regulation 17 Good governance

Summary of findings

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before the inspection, we reviewed information that we held about child and adolescent mental health wards and requested information from the trust. This information suggested that the ratings of good for effective, caring, responsive and well led, that we made following our December 2015 inspection, were still valid. Therefore, during this inspection, we focused on those issues that had caused us to rate the service as requires improvement for safe. We also made a few recommendations at the last inspection which will be followed up at the next comprehensive inspection.

During the inspection visit, the inspection team:

- visited Berkshire adolescent unit and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with eight patients who were using the service
- reviewed 15 comment cards from people using the service and their carers
- spoke with the service manager and the ward manager for the unit
- spoke with eight other staff members including consultant psychiatrists, nurses, healthcare assistants and psychologists
- reviewed five care records
- reviewed eight medication charts

looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the provider's services say

We reviewed 15 comment cards from patients and their carers. Nine comment cards were overwhelmingly positive about the staff. They reported staff were respectful, kind and helpful. Parents were extremely grateful for the service and the support provided.

Six comment cards gave mixed responses. The negatives were mainly around the use of agency staff, lack of one to one time with nurses and lack of individual therapy.

We spoke with eight patients on the unit. They told us that permanent staff and long term agency staff were all great and spent time with them and cared about them. However, patients had little confidence in less regular agency staff and reported some agency staff did not take them seriously and did not help young people at risk of self harm. They reported they could feel unsafe, especially at night when agency staff were more likely to be on duty. Patients also reported they would like more activities off the unit and more individual therapy time.

Areas for improvement

Action the provider **SHOULD** take to improve

- The provider should ensure all relevant staff are trained in the prevention and management of violence and aggression.

- The provider should ensure that details of every incident of restraint are recorded fully.

Berkshire Healthcare NHS Foundation Trust

Child and adolescent mental health wards

Detailed findings

Name of service (e.g. ward/unit/team)

Berkshire Adolescent Unit

Name of CQC registered location

Berkshire Adolescent Unit

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Safe and clean environment

- Lines of sight around the unit were poor and staff could not observe all areas of the unit from the nurses' office. However, staff ensured they regularly monitored all areas of the unit. Ligature risks were present throughout the unit. A ligature point is anything that could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. However, the concerns raised at the last inspection regarding ligature risks had been addressed through a programme of work and the trust had implemented robust procedures to mitigate the risk of ligatures. For example, anti-ligature fittings were installed throughout the unit. We reviewed the ligature risk assessment which was thorough and up to date. All ligature points were identified in this assessment and the risks adequately mitigated. For example, staff recently identified ligature risks in the school toilet. Management immediately arranged a review by estates and closed off the toilet until the works could be completed to ensure safety.
- The trust provided all staff with ligature training in April 2016 and planned further training dates for new starters. Induction packs for new starters included a demonstration of ligature risks and how to report new risks. Staff implemented daily checks of the unit at each shift change and reported new ligature risks to the manager and took immediate action to mitigate the risk. Staff contacted out of hours estates to resolve the issue if necessary. We saw the ligature check present on the daily handover sheets. All staff we spoke to reported these always happened. Staff identified high risk areas such as the games room, lounge and dining room and ensured they regularly monitored these areas. Patients only used the kitchen with staff supervision. Floor plans of the unit identifying high risk areas were on the office walls. Staff observed all patients four times each hour due to the design and layout of the building, including static ligature risks. Staff placed new patient admissions in bedrooms near to the nursing office where possible in order to observe more easily.
- Staff undertook regular environmental risk assessments and this formed part of the wider unit risk register. These were up to date and reviewed regularly. We reviewed both and found them to be thorough and comprehensive with the level of risk, action and timescales clearly identified. Issues raised at the last inspection had been resolved. Bedroom doors had observation windows and two way mirrors were present in assessment rooms on the main ward. Staff kept the door to the garden locked due to security issues but patients could access the garden on request.
- The environmental risk assessment included fire risk. We noted this was updated in November 2016 and included a local evacuation plan and fire evacuation training for staff. The local induction policy for new staff included fire procedures. All fire extinguishers were kept in safe staffing areas and were not accessible to the young people.
- The unit complied with the Department of Health guidance on gender separation. The unit was mixed sex and sleeping accommodation was situated in a mixed sex corridor. Patients stayed in single bedrooms which were not en suite. The unit ensured same sex guidance was achieved by designating male and female bedrooms at either end of the mixed sex corridor. Toilet and washing facilities were designated male and female with clear signage and situated at either end of the corridor. There was a disabled toilet and shower room that could be designated for either gender. Managers ensured a staff member was always present in the corridor overnight from when the first young person went to bed until 8.30 am the following morning. We were satisfied that concerns raised at the last inspection regarding same sex accommodation had been resolved.
- There was no female only lounge. The inspection team was satisfied that the unit was built before 2000 and had not undergone any major refurbishment since this time. A female only lounge is therefore not mandatory, although would be good practice. The unit had no reasonable solution to provide this facility. Managers told us that discussions with commissioners about moving to a more appropriate setting were ongoing. No date had been set for this.

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

- The clinic room was clean and compact. There was a locked fridge with visible temperature readings that staff checked regularly. Couch, scales and height monitor were present for physical examinations. The unit had no electrocardiogram machine which would be beneficial. Staff checked oxygen cylinders daily and checked the defibrillator machine weekly. Staff regularly checked the resuscitation equipment located in the staff office. Staff ensured they kept emergency drugs within a locked cabinet within a locked room. Ligature cutters were kept in the staff office.
- All areas of the unit were clean. The inspection team saw a cleaning rota present in every room evidencing regular checks and daily and weekly cleaning tasks. Patients were able to choose the furniture, which was young person friendly. However, the family room and de-escalation room looked worn and would benefit from refurbishment.
- Staff adhered to infection control principles. The inspection team reviewed the last three months infection, prevention and control audits. These evidenced 84% compliance. The audits noted any action required and the person responsible for carrying this out. There was no space on the form to evidence staff completed this, which could lead to actions not being completed. For example for two months in a row we noted the sharps bin was unlabelled and no action taken. The hand hygiene monitoring tool checked the use of soap, water and alcohol foam and evidenced 100% compliance by staff for the last three months.
- The operational policy required staff to wear allocated alarms at all times and we saw this was happening. The unit operated a pin point alarm system in the event of an alarm being triggered. All rooms within the main unit including bedrooms, bathrooms and assessment rooms were equipped with nurse call buttons.
- The trust reported two band six nurses in post and two vacancies. However, one vacancy had been filled and a start date was agreed. There were six band five nurses in post and two vacancies. There were eight band three health care assistants in post and four vacancies.
- The trust reported in the period September 2016 to November 2016, 472 shifts needed cover. Of these, 266 were filled by agency staff, 183 by bank staff and 23 were unfilled. Staff turnover December 2015 to November 2016 was high at 39%. Staff sickness December 2015 to November 2016 was low at 3%.
- The trust recognised these issues with staffing and implemented robust action plans to deal with this. A regular service manager had been in post since August 2016 and this provided stability. The trust implemented ways to attract and retain staff and wider consultation with the staff team was happening. Ideas included progression opportunities for band five staff to band six, and the creation of band four posts. Ideas around the wider therapy team to include a social worker and occupational therapist were also evolving. The trust based new staffing levels on national standards and what was needed at local level.
- The trust contracted regular agency staff to the unit and gave three agency staff members regular shifts one month in advance to maintain stability. The trust ensured regular agency staff accessed the electronic patient records. One agency worker was recently recruited to a permanent staff role.
- The unit ensured a minimum level of staff on duty at any one time. A minimum of six staff would be on the day shift with at least two qualified nurses. At night a minimum of four staff with two qualified nurses staffed the shift. This may be reduced in accordance with the number of inpatients at any given time and the clinical dependence. The manager had authority to increase staffing levels when indicated. Staffing rarely fell below these levels. The manager completed monthly staffing reports to the board and reported all staffing issues as incidents.
- All staff we spoke to reported an enormous improvement in staffing. Staff reported they rarely needed to cancel patients' leave and activities, although leave was at times delayed if there was a shortage of staff.

Safe staffing

- Staffing at the unit remained an issue and high use of agency staff was on the risk register. However, managers and staff we spoke to all reported staffing levels were improving and were overwhelmingly positive about the new management in place since August 2016.

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

- Patients we spoke to reported leave was rarely cancelled although they also reported that one to one time with key nurses did not happen regularly. They reported that not enough activities took place off the unit. Staff were aware of their concerns and ideas were discussed in community meetings.
- We reviewed the induction pack for agency staff members. The manager ensured they allocated a mentor to each new staff member to implement a mini induction. This included orientation to the unit, incident reporting, observation policy, ligature checklists and infection control. We spoke with one agency worker who confirmed they received a thorough induction to the unit.
- The trust employed other allied health professionals such as psychologists, art/music therapists and a dietician. These posts were fully staffed.
- The trust provided adequate medical cover for the unit. This included two part time consultants and two junior doctors. The unit contacted out of hours doctors when needed.
- The trust provided a number of mandatory and statutory training courses. Statutory courses included fire safety, health and safety and manual handling. Staff compliance was at 75% or above in these courses. Mandatory training included clinical risk assessment at 86%, infection control at 80%, and information governance 85%. Safeguarding adults level one was at 77% and safeguarding children level two was at 100%. Best practice states staff on a child and adolescent unit should all be trained to safeguarding children level three and this was a unit target. Currently 75% of staff had completed training to this level. Prevention and management of violence and aggression training compliance was at 69%. The unit recognised this as an issue and placed this on the ward risk register with an action plan to ensure all staff undertook this training, including new staff members and long term agency staff.
- The unit recently provided bespoke training on the Mental Health Act, Mental Capacity Act and parental responsibility. Twelve staff members attended this training in October 2016. Twenty one staff attended training in the Mental Health Act and Deprivation of

Liberty Safeguards in May 2016. Staff we spoke to showed an understanding of Gillick competence which is a way to assess competency for making decisions in children under 16.

Assessing and managing risk to patients and staff

- Berkshire adolescent unit did not have a seclusion room. There was a de-escalation room on the unit that staff used to enable a young person to calm down if needed. Staff sat with the young person until they felt ready to rejoin the community. The inspection team were satisfied staff used this appropriately and it did not amount to seclusion. The unit never used long term segregation.
- The unit operational policy stated there was no provision for seclusion or high dependency and therefore they would not accept admissions for young people with a high risk of violence, aggression or challenging behaviours. Staff reported this was the case.
- The trust reported 17 restraints on the unit between January and November 2016. Staff reported they recorded all restraints as incidents. We reviewed the data on the restraints and found that in all cases staff classed the severity of the incidents as low (no injury) or minor (superficial harm, no permanent injury). Generally, staff documented use of restraint appropriately. However, one restraint was reported as being prone restraint. This was not well documented and the length of time of the restraint was unclear. Intra muscular medication was also used in this restraint but was not recorded as rapid tranquilisation. Staff did monitor the patient appropriately following this intervention.
- All staff reported they rarely used restraint and they used de-escalation techniques in the first instance. We reviewed the trust policy on prevention and management of violence and aggression (PMVA). All new staff attended training in de-escalation using the promoting safer and therapeutic services syllabus. This is designed to give staff the skills and confidence to recognise and diffuse potentially volatile situations before they escalate. Staff also attended breakaway techniques as part of their induction and all staff on the Berkshire adolescent unit attended a five day PMVA teamwork course. All staff undertook an annual refresher in this course. The trust recognised not all staff

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

had accessed this training and put this on the ward risk register. In November 2016 compliance increased to 69% and the trust expected to achieve full compliance by February 2017. Staff reviewed the number of substantive staff who were PMVA trained when booking agency and bank staff to ensure sufficient numbers of trained staff on each shift.

- We reviewed five out of nine care records. All five included clear, detailed and up to date risk assessments covering a range of domains. All five included risk management plans, which clearly identified triggers and protective factors. The risk management plans fed into the care plans for individual patients. Staff completed a full risk assessment for each patient on admission and reviewed this after 72 hours and then weekly as a minimum. Patients and families were involved in these assessments. Psychology provided input into risk formulation at the weekly multidisciplinary team meetings. The inspection team concluded that concerns raised at the last inspection around risk assessments were resolved.
- All staff we spoke to were aware of risk assessment. The unit provided in house training and implemented live supervision for staff. This was where the trainer sat with the staff member and completed a current risk assessment and management plan. Supervision sessions included risk triangulation on the agenda. The trust provided a rolling programme of comprehensive risk assessment and management training from May 2016 that included new starters and agency and bank workers. The trust trained agency and bank staff on longer term contracts in the patient electronic record system, meaning these staff could access up to date risk assessments. The trust planned to roll this training out to less regular bank staff and eventually ad hoc bank staff, ensuring all staff received relevant patient information. We spoke with one long term agency worker who confirmed access to the electronic system.
- Staff followed the trust policy on patient observations. Staff placed all new admissions on level two observations, which is within eyesight at all times, for a minimum of 24 hours. Following review, all patients were on level three observations at all times. This meant staff checked on patients four times each hour. This was partly due to the layout of the building and the management of poor lines of sight and static ligature risks. Staff increased or decreased observation levels based on individual patient risk as needed.
- Five patients we spoke with reported they had seen agency staff falling asleep during the night shift. These were on different occasions and concerned different staff members. We immediately brought this to the attention of the service manager who was aware of this issue. The trust had carried out an unannounced night time visit and following discussions with patients no longer used three agency staff members implicated in these incidents. We were satisfied the trust was dealing with these concerns.
- Prior to our inspection the ward had had situations where contra band items were smuggled into the ward. Therefore, staff searched all patients on return from leave using a wand metal detector. Staff pat searched patients if necessary and clearly documented this in their care plan. Patients we spoke with reported they were happy to be searched but also felt they could still bring in items that were not allowed and that procedures were not always thorough enough.
- Staff regularly informed patients of their rights and informal patients could leave at will. The unit displayed signs explaining patient rights.
- We reviewed eight prescription charts and found these to be in good order. All displayed patient photographs except one, as the patient had refused. We found the medicine records to be thorough and as required medicines regularly reviewed at least every 14 days. Staff very occasionally dispensed medication from ward stock. Staff followed trust policy when implementing this and this policy met legal requirements and provided a safe system for doing this.
- The trust reported three safeguarding referrals made to the relevant local authorities in the last six months. Staff reported awareness of safeguarding procedures and accessed safeguarding training. The trust employed a safeguarding lead who held monthly safeguarding supervision sessions for staff. Trust policy stated all staff must attend at least three of these sessions in a 12

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

month period. The unit manager reported this had been happening regularly for the last year. Staff felt confident in identifying and reporting safeguarding issues including historic disclosures of abuse.

- We reviewed five care records and found safeguarding risks, where they had been identified, were clearly recorded in the notes. One care record included a detailed child in need plan. Staff recorded who had parental responsibility for the young people in the notes.

Track record on safety

- The trust reported no serious incidents at the Berkshire adolescent unit in the last 12 months. The trust defined a serious incident as any event or occurrence that has led to moderate or severe harm or death, or harm for an extended period of time. Such incidents require investigation by the trust.
- The unit reported one incident involving two patients going absent without leave. They rated this as a sub serious incident. This resulted in the unit updating their absent without leave policy to ensure this would not happen again and changing door codes regularly to improve security. Managers also attended partnership meetings with the police and ambulance service and discussed how to respond to such incidents.

Reporting incidents and learning from when things go wrong

- The manager reported that the process of reporting and learning from incidents was embedded in the unit procedures. All staff we spoke to, including agency staff, confirmed this and knew what and how to report. Examples of incidents reported included self harm, verbal abuse and medication errors.
- We reviewed incident reports and saw evidence that staff reported these appropriately. We noted that staff reported all restraints as incidents in line with the policy and we saw records of all restraints which occurred since January 2016. The ward manager reviewed and signed off all incidents.
- Managers ensured learning from incidents and debriefing following incidents took place. The unit held weekly debriefing meetings, and discussed and reviewed recent incidents at these meetings. We

reviewed minutes of these meetings and found evidence that learning was implemented following incidents. All staff were invited to attend these meetings and recognised that these meetings offered valuable space for reflection, learning and support. Staff also discussed good practice at these meetings.

- We reviewed an incident involving restraint and found that only one permanent member of staff was trained in the prevention and management of violence and aggression (PMVA) in May 2016. The restraint was carried out with an agency staff member who used different techniques. No injury occurred as a result but could potentially have resulted in harm to staff or patient. Staff reported this incident and management identified PMVA training for all staff as a need and the risk added to the ward risk register. The unit implemented a robust action plan to ensure enough staff accessed training in PMVA. Compliance increased to 69% by the time of our inspection.
- The unit implemented a debriefing policy following incidents. This document outlined the support delivered to staff following incidents and stated debriefing sessions should take place within 24 hours of the incident. All staff we spoke to reported that debriefing took place. The trust provided independent support in addition if needed. We were satisfied that concerns raised at the last inspection regarding the lack of staff debriefing had been resolved.
- Staff also debriefed patients following incidents. The advocacy group held on the ward had raised the lack of this as an issue and management implemented this process so that young people were supported following any incident. Staff and young people confirmed this took place.

Duty of candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.
- The Berkshire adolescent unit debriefing policy included duty of candour and set out the procedures staff should follow if this were triggered.

Are services effective?

Good 

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our findings

At the last inspection in December 2015 we rated effective as **good**. Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

Are services caring?

Good 

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Our findings

At the last inspection in December 2015 we rated caring as **good**. Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

Are services responsive to people's needs?

Good 

By responsive, we mean that services are organised so that they meet people's needs.

Our findings

At the last inspection in December 2015 we rated responsive as **good**. Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

Are services well-led?

Good 

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

At the last inspection in December 2015 we rated well-led as **good**. Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.