The Huntercombe Hospital Norwich

Quality Report

Huntercombe Hospital
Buxton Road
Norwich
Norfolk
NR10 5RH
Tel: 01603 277100
Website: www.Norwich@Huntercombe.com

Date of inspection visit: 13 - 14 March 2017 and 23 March 2017
Date of publication: 19/05/2017

This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Requires improvement
Are services safe?	Inadequate
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Requires improvement

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

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

Summary of findings

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

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

Overall summary

We rated Huntercombe Hospital Norwich as requires improvement because:

- Some staff reported that at times the wards were left with no registered nurse for a short period. This was when one nurse took a break and the other nurse responded to an emergency on another ward. We raised this concern with the provider who gave the concern immediate attention to prevent this from happening again.
- We did not see evidence of review of supportive observations. For instance, one record showed a patients increasing risk but there was no clear plan of how to manage this risk. There was no evidence of review of the patient's observation levels in the ward round held by the Consultant in light of the increased risk. Lack of review of increasing risks could lead to a serious incident.
- Staff did not follow their own policy that says there should be a review of patient's supportive observations daily and there should be a daily entry in the patient's clinical notes specifically relating to supportive observations.
- There was no audit of supportive observation or of rapid tranquilisation. The provider did not identify concerns relating to these areas.
- Staff did not complete any of the reviewed rapid tranquilisation records correctly. None of the rapid tranquilisation physical health monitoring was completed in line with the hospital's own policy or best practice.
- Prescribing of rapid tranquilisation was not in line with the hospital's own policy.
- Staff did not routinely assess individual patients capacity and competency and they lacked understanding of this process.
- Two patients under the age of 16 had capacity assessed under the Mental Capacity Act 2005 (MCA). Only patients over 16 years old should be assessed using the MCA. Those under 16 years old should have competency assessed by a doctor using the Gillick assessment.
- In three cases, the Responsible Clinician (RC) did not update the patient's consent form.
- Some staff were not clear about the role of the independent mental health advocate (IMHA). It was not clear from patients' notes whether any patients had been referred to the IMHA.
- We checked nine seclusion records and we found that seven were not completed in line with the MHA code of practice.
- Male patients' had to walk passed the female bedrooms to access the communal areas, or be escorted outside around these areas. This was a breach of the Mental Health Act code of practice regarding mixed sex accommodation.
- Some policies provided by the Huntercombe Group were out of date, such as the Supportive Observation Policy, which was due to be reviewed in September 2016.

However:

- Between 19 June 2016 and 19 December 2016 there were 893 restraints used on 52 different patients. There were 1688 restraints in the previous 6 month period between June and December 2105. This was a reduction of 795 restraints. Although there had been a period of time in 2016 with bed number reductions, this represented a downward trend and demonstrated that the hospital was working to reduce the number of restraints.
- The hospital had mitigated some safety observation risks by installing mirrors and CCTV in the main ward areas.
- We reviewed 12 patient records and all had a comprehensive risk assessment completed on admission, which staff had updated regularly.

Summary of findings

- Care records showed that doctors completed physical examinations for all 12 patients whose records were reviewed, and there was evidence of ongoing review of patient's physical health needs.
- We saw innovative practices such as the use of staff own dogs with patients in a therapeutic environment. This was risk assessed for both the dogs and patients safety.
- The occupational therapy assistant had completed a course of camouflage make up and had introduced sessions with patients who requested it.
- The hospital invested in specialist training courses for staff.
- Rainforest ward received a participation certificate for the Quality Network for Inpatient CAMHS, awarded in October 2016.
- There were strong links with the school, which was located on site, and had received a 'good' rating from Ofsted. The school and ward communication was well established and every effort was made to encourage school participation and a variety of educational courses were available.

Senior managers provided effective leadership within the hospital.

Summary of findings

Contents

Requires improvement

Location name here

Child and adolescent mental health wards

Summary of this inspection

Background to The Huntercombe Hospital Norwich

The Huntercombe Hospital Norwich is a low secure facility providing inpatient child and adolescent mental health services (CAMHS) for young people aged between 12 and 18. The service provides care to people with a range of mental health disorders and who are detained under the Mental Health Act.

The regulated activities are:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Treatment of disease, disorder or injury

The hospital provided assessment and treatment for up to 35 young people. At the time of the inspection, there were 28 patients on three wards, 27 of whom were detained under a section of the Mental Health Act. Rainforest has 12 beds and Coast Ward has 11 beds. Both were mixed sex low secure units, each supporting young people with mental health conditions. Sky Ward was a psychiatric intensive care unit. This ward supported up to 12 young people until recently, when NHS England (NHSE), as the lead commissioner, reviewed the need for this service and at the time of inspection there were five beds commissioned for use. However, NHSE made two exceptions due to increased national demand and there were currently seven young people on the ward.

The site had a total area of 17 acres and there was a range of horticultural and recreational facilities. Each ward had a locked door to maintain the security of each unit and the grounds.

The registered manager is Pauline Goffin.

The controlled drugs accountable officer is Sandy Watt.

This was an announced comprehensive inspection. We followed up with an unannounced inspection on 23 March 2017. This was carried out following further concerns identified and reported to the Commission by the provider.

The Care Quality Commission last inspected the hospital in February 2016. Following the inspection, we served a requirement notice against Regulation 17 HSCA (RA) Regulations 2014 Good governance

Specifically, the recording of section 17 leave did not meet the MHA Code of Practice guidance.

This was a breach of regulation 17 (2) c.

Following this inspection we found:

Staff completed Section 17 leave forms consistently. All patients had up to date forms in place.

Our inspection team

Team leader: Jane Crolley inspector Care Quality Commission

The team that inspected the service comprised four CQC inspectors, a Mental Health Act Reviewer and a pharmacy inspector.

The follow up inspection was carried out by an inspection manager and inspector.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme. This was an announced inspection.

Summary of this inspection

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 the service and asked another organisation for information. We visited the site for three days in total, two days as announced visits and one day unannounced.

During the inspection visit, the inspection team:

- visited each ward and looked at the quality of the environment and observed how staff were caring for patients
- met with eight patients who were using the service
- interviewed the registered manager, ward managers and acting ward managers for each of the wards
- interviewed 13 other staff members; including doctors, nurses, occupational therapist, psychologist, head teacher and social worker
- attended and observed one multi-disciplinary meeting and one group
- collected feedback from two patients using comment cards
- spoke to two carers
- reviewed in detail 12 care and treatment records of patients
- examined four staff files
- reviewed HR and training records
- carried out a specific check of the medication management on three wards
- examined a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

Patients said they felt safe and looked after in the hospital. They said staff were supportive and some patients informed us staff were amazing.

Patients said they were listened to and staff responded to their needs and were respectful. Patients also told us it was a great place to receive care.

Patients said they could write their own care plans and had support to do this. They appreciated access to the school and the ability to continue their education when well enough to do so.

Patients knew how to complain and received feedback when a complaint was raised.

Patients confirmed there were activities throughout the week and enjoyed the special events that they helped plan.

However, one patient felt that staff were too soft and should take control when faced with violence. One patient said they had not been able to access fresh air due to their current risk assessment.

Carer feedback was positive. They reported being included in decisions and listened to. They said they received regular updates and were able to speak to staff. One carer did say at times it was frustrating getting through to the ward on the phone but staff were always responsive when contact was made.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

We rated safe as inadequate because:

- Some staff reported that at times the wards were left with no registered nurse for a short period. This was when one nurse was on a break and the other nurse responded to an emergency on another ward. We raised this concern with the provider who gave the concern immediate attention to try to prevent this from happening again.
- Staff were not following NICE guidance on the prescribing, administering and monitoring of rapid tranquilisation. This was raised with the provider during inspection to address.
- The hospital recently updated the rapid tranquilisation policy but it did not reflect National Institute for Clinical Excellence (NICE) guidance for the administration of rapid tranquilisation medication on young people. We looked at 37 rapid tranquilisation observation charts. None of the physical observations where completed in line with policy or best practice. The service did not assure us that patients were safe during this period of treatment and they did not audit the use of rapid tranquilisation.
- Prescribing of rapid tranquilisation was not in line with policy.
- We saw records of patient observations in care records. Most of the records were completed and up to date, however on Sky ward we observed staff completing the observations retrospectively. We raised this with the manager who advised that staff kept the recording sheet in the office as it may be used as a weapon or be destroyed. The ward manager said that staff were expected to go to the office every time the board needed completing which could be every 15 minutes. This was not an effective practice of carrying out and recording observation.
- We did not see evidence of the review of supportive observations in clinical records. For instance, one record showed a patients increasing risk but there was no clear plan of how to manage this risk. There was no evidence of review of the patient's observation levels in the ward round held by the Consultant in light of the increased risk. Lack of review of increasing risks could lead to a serious incident.

Summary of this inspection

- Staff did not follow their own policy that says there should be a review of patient's supportive observations daily. There should be a daily entry in the patient's clinical notes specifically relating to supportive observations but there was no evidence of this.
- We reviewed the provider's supportive observation policy. This was due for review in September 2016. The hospital managers advised they had requested an update for those policies that had recently gone out of date.
- Staff did not consistently review and update care plans following a risk incident.
- We noted that there were at least two occasions where on-call medical staff did not respond to an initiated seclusion within the required one-hour period and on one occasion did not attend at all. There is a requirement for a doctor to review a patient timely, following a decision to utilise seclusion, to ensure the patients safety and physical wellbeing.
- The seclusion care plans we examined did not meet the recommendations of the MHA 1983 code of practice. For example, there was no statement of clinical need, no plan as to how needs were to be met nor details of how family, carer or parental responsibility communication would be met.
- The male patient had to walk past the female bedrooms to access the communal areas, or be escorted outside around these areas. There were no ensuite facilities in bedrooms and processes in place to manage risk impacted on the male patients ability to move within the ward freely. This was a breach of the Mental Health Act code of practice regarding mixed sex accommodation.
- Staff could not observe all areas of the ward to maintain patient and staff safety. The hospital had some mitigation to risk by locking rooms, installing mirrors and CCTV installed in the main areas. The nurse office did not have any observation of corridors partly due to staff putting up posters on the windows.
- The central clinic room was overstocked and untidy. We saw several items of stock medication that was out of date. Internal audits had not identified this. We advised the provider of this concern.

However:

- Between 19 June 2016 and 19 December 2016 there were 893 restraints used on 52 different patients. There were 1688 restraints in the previous 6-month period between June and December 2105. This was a reduction of 795 restraints.

Summary of this inspection

Although there had been a period in 2016 with bed number reductions, this represented a downward trend and demonstrated that the hospital was working to reduce the number of restraints.
- There were no incidents of prone restraint.
- We saw evidence in patient care plans and clinical notes of efforts to de-escalate prior to the use of restrictive practices such as restraint or seclusion.
- We reviewed 12 patient records and 11 had a risk assessment completed within 24hrs of admission.
- The hospital had an organisational structure to support safe management of medicines.
- The hospital conducted monthly medicine management meetings to discuss good practice, medicine incident and shared learning.
- We saw effective systems in place to report and review safeguarding concerns.
- There were arrangements in place to enable children to visit using designated rooms on site. There were also facilities to accommodate visitors overnight due to the distance travelled by some relatives. There was a risk assessment process in place for children visiting the hospital and if a family visited, which included a child, then the accommodation would not be shared with another family.
- There was evidence of debriefs following incidents and the more serious incident debriefs were held by senior staff such as the Clinical Psychologist or Hospital Director. Findings were shared with staff following the review.

Are services effective?

Requires improvement

We rated effective as Requires Improvement because:

- We did not see any information in care plans relating to identification of relapse prevention. There was no evidence of identification of early warning signs.
- The care plans did not reflect multidisciplinary team goals.
- The Responsible Clinicians were not updating consent when a patient's medication had changed; this meant we could not be sure that the patient had consented to that change.
- Staff did not routinely offer families copies of Section 17 leave arrangements, which is against MHA code of practice guidance.
- We reviewed the records of one patient who had been in long-term segregation. There was evidence of rationale for the decision via a multi-disciplinary team. However, there were gaps in the process with no record of a safeguarding referral, nor a referral to the independent mental health advocate.

Summary of this inspection

There was no record of where the segregation took place, or plans for the patient to access fresh air, activities or mealsStaff did not record clearly in patient records who had parental responsibility.

- Three staff spoken to were not clear about the role of the independent mental health advocate (IMHA). It was not clear from those patients' notes reviewed whether staff had referred any patients to the IMHA.
- Some staff did not have a good understanding of the Mental Capacity Act 2005 (MCA). Staff did not routinely assess the children and young people's capacity/competence and record consent status with regard to treatment within the first three months of their treatment for mental disorder as per the code of practice.
- The MCA does not apply to children under the age of 16. For children under this age, the young person's decision-making ability is informed by an assessment of Gillick competence. We found a mixed ability of understanding by staff. We found in two records that a staff member had assessed a young person under 16 using the Mental Capacity Act, which was incorrect. Children did not have their competency/capacity assessed and their consent recorded with regard to treatment within the first three months of treatment.
- We examined seclusion records and we found that out of nine checked, seven were not completed in line with the MHA code of practice.

However:

- We saw innovative practices such as the use of dogs with the patients. There were three dogs on site most days. The relationship between the patients and dogs was evident. The occupational therapist and social worker worked with the patients and dogs, which helped them at times of risk of self-harm, acting as a companion and a distraction from harmful thoughts. The patient was able to find comfort from the dogs and there some early evidence of improved engagement in sessions.
- We saw that the occupational therapy assistant had completed a course of camouflage make up. This skill helped the patients cover their scars and access the community with confidence.
- We saw investment in staff specialist training, particularly around dialectical behaviour therapy (DBT) and positive support plans (PBS). This was in the early stages with a full

programme of training planned to improve the therapeutic skills of all staff. DBT is a type of talking therapy designed to help people suffering from mood disorders as well as those who need to change their pattern of behaviour.
- Clinical psychology input was embedded and the team had expanded and included psychology assistants and access to art therapy. The clinical psychologist and occupational therapist was heavily involved in the development of the DBT training for staff and provided individual staff and group supervision.
- Care records showed that doctors completed physical health examinations for all 12 patients whose records were reviewed and there was evidence of ongoing review of patient's physical healthcare needs.

Are services caring?

Good

We rated caring as good because:

- We observed positive interaction between patients and staff. We found that staff responded in a caring, non-judgemental and kind manner towards patients whose behaviours could be challenging at times.
- Staff had a good understanding of individual patient needs. They knew individual patients and their likes, dislikes, care plans and risks.
- Patients spoke of being involved in their care plans. We saw that staff offered patients a copy of their care plan and patients' were invited to attend and contribute at their care reviews.
- We spoke to two carers. They were very positive about the care their child had received.
- There was accommodation for up to two families so those travelling a long way could stay over free of charge. There was a risk assessment process in place and if a family visited with a young person then the accommodation would not be shared.
- The hospital had introduced a new initiative called #pizza chat. This gave the patients a forum to discuss issues important to them and raise any concerns, which were then discussed and actions agreed.

Are services responsive?

Good

We rated responsive as good because:

- There was a range of rooms and equipment to support treatment and care. We saw good use of the small clinic rooms on the wards, activity rooms, quiet areas, visitors' rooms and therapy rooms.

Summary of this inspection

- Bedrooms were personalised, patients were able to put posters on their walls. We saw that recently patients had been involved in making decisions on colour schemes in bedrooms.
- There was secure space for personal possessions in the bedrooms although most young people did not have a key due to individual risk assessments.
- The young people's educational needs were met onsite with a school located close by in the grounds of the hospital. The school was rated as 'good' following the Ofsted inspection in June 2016 with personal development, behaviour and welfare rated as 'outstanding'. We saw teachers providing educational work to do on the wards when the young person was unable to attend school and there were strong links between both services ensuring effective communication.
- There was a programme of weekly activities with occupational therapy team input seven days per week. Staff supported activities off site where section 17 leave was permitted. There was a timetable of events for young people to engage in planning and delivering, such as Red Nose day events and other special days.
- Each ward had a welcome pack with a range of information to assist with the initial admission. The welcome pack had details on how to make a complaint.
- We saw that staff responded to patient complaints swiftly and letters were provided as part of the response, which included any action taken if appropriate.

However:

- There were no information leaflets available on the wards about health related matters available to patients.
- We saw that staff discussed complaints at the team meeting but there was no evidence of what lessons were learned. For example, the minutes concentrated on the number of complaints as opposed to the nature of the complaint.
- The hospital did not have facilities to provide care and treatment for patients with a significant physical disability.

Are services well-led?

Requires improvement

We rated well led as requires improvement because:

- While there was management information available to ward based managers, there was no monitoring system in place to ensure that this was being understood or followed by ward based staff.
- Attendance of Mental Health Act and Mental Capacity Act training was high. However, this did not appear to improve compliance in certain areas, for instance, capacity and consent.

Summary of this inspection

- Ward managers moved wards to try to cover shortfalls. This left a lack of direct leadership to front line staff.
- Ward managers did not get information broken down to ward level. Management information such as training attendance, supervision, incidents and feedback from complaints were provided at service level. This meant managers could not easily access this information to promote improvements at ward level.
- There was no audit of rapid tranquilisation or of supportive observation. The provider did not identify concerns relating to these areas.
- Policies were not all up to date. For instance, the supportive observations policy was due for review in September 2016.
- Front line staff were not aware that they could add items to the hospital's risk register and had limited knowledge of what risks were currently on the register.

However:

- We found that management and governance systems in place were appropriate for senior staff to determine the strengths and development needs of the organisation. We saw evidence of management information such as attendance of staff at mandatory training and supervision engagement and appraisal completion.
- Senior managers recognised the amount of work that still needed to be done to improve the safety and care of patients.
- Systems were in place for the provider to learn from incidents, complaints and ensure there was patient and staff feedback from surveys.
- Monthly local clinical governance meetings and senior management team meetings took place. Agenda items included audits, updates to the local risk register, environmental concerns, safe staffing and patient care.
- There was a detailed risk register, which managers reviewed monthly at both the senior management team meetings and local clinical governance group meetings.
- Staff had the opportunity to access further courses for their own professional development. We saw a range of courses, such as a Masters course in therapeutic interventions, leadership courses and the care certificate. There was physical healthcare training such as phlebotomy and ECG recording available. Staff felt supported to improve their skills and knowledge.

Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

- 27 of the 28 patients on site were detained under the MHA 1983. Staff had advised the informal patient of their rights and the hospital was looking urgently for a bed in an open setting. At the time of inspection, the patient had been on the ward as an informal patient for 5 days following the tribunal's decision to remove the patients section.
- Ninety two percent of staff had completed MHA training.
- Patients were advised of their right to appeal against their section and how to do this and we saw evidence of hearings and referrals to tribunal in accordance with the patients statutory rights.
- Section 17 leave forms were up to date, reviewed regularly and completed accurately. Staff did not offer families copies of Section 17 leave arrangements, which was against code of practice guidance 27.22.
- Of 13 records reviewed, 12 confirmed that staff had informed patients' of their rights on admission to hospital.
- Staff did not meet their own policy of informing of rights on a weekly basis. Those records reviewed showed patients were informed of their rights anywhere between 2 and 6 weeks.
- Staff did not record clearly in patient records who had parental responsibility.

The MHA administrator completed regular audits to ensure that the MHA was applied correctly. If there was a concern the MHA administrator would advise the appropriate people.

- We found that out of nine seclusion records checked, seven were not completed in line with the MHA code of practice.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff completed mandatory Mental Capacity Act (MCA) training which included Gillick competence (for children under the age of 16, the young person's decision-making ability is governed by Gillick competence. The concept of Gillick competence recognises that some children may have sufficient maturity to make some decisions for themselves). Training completion compliance was 92%.
- The MCA does not apply to children under the age of 16. For children under this age, the young person's decision making ability is informed by an assessment of Gillick competence. We found a mixed ability of understanding by staff. Some staff interviewed were familiar with this process whilst others, including registered nurses, were not. We found in two records that a doctor had assessed a young person under 16 year old under the Mental Capacity Act, which was incorrect.
- Children did not have their individual competency and capacity assessed and their consent recorded with regard to treatment within the first three months of treatment. Therefore there was a risk that young people were not being involved in the decisions about their treatment.
- Senior managers were in the process of developing a training plan to improve individual staff knowledge and understanding.

Requires improvement

Child and adolescent mental health wards

Safe	Inadequate
Effective	Requires improvement
Caring	Good
Responsive	Good
Well-led	Requires improvement

Are child and adolescent mental health wards safe?

Inadequate

Safe and clean environment

- Staff could not observe all areas of the ward to maintain patient and staff safety. The hospital had some mitigation to risk by locking rooms, installing mirrors and CCTV installed in the main areas. The nurse office did not have any observation of corridors partly due to staff putting up posters on the windows.
- We spoke to one senior nurse on the ward who was not aware of ligature audits or environmental risk areas for the ward. Each ward had a ligature audit; however, these were not easily available for staff to refer to. This meant that staff could not mitigate potential risk to patients.staff called
-
- All three wards were mixed sex, although at the time of the inspection Coast ward had female patients only. The bedrooms for the male patients on Rainforest were at the end of the corridor, the males had to walk past the female bedrooms and bathroom (the rooms were not ensuite). The male patient could access the main ward via a different entrance to reduce the need for walking down the corridor; however, there was frequent occasion when this was not viable and would also restrict the male patients freedom of movement. This was a breach of the Mental Health Act code of practice regarding mixed sex accommodation.
- The clinic rooms on the wards were well-organised and carried minimum stock of medication, which made it easy for staff to access. Regular checks took place and staff recorded room temperatures. We saw evidence of an action plan to purchase air conditioning units in response to temperatures being above acceptable level. The emergency equipment was kept in the locked nurse office for ease of access in a sealed bag.
- There were two seclusion rooms, one on Coast ward and one on Sky ward. Staff could alter the room temperature; there was a window that let in natural light, a mattress, bedding, and toilet facilities.
- Wards were clean and the corridors were pleasantly decorated. However, the link areas used by patients were bare and there was minimal furniture.
- Maintenance was taking place on Sky ward without a risk assessment in place to protect patients and staff.
- Hand-washing posters were visible in wards areas and hand gel dispensers were available at ward entrances.
- Staff could not exit some patient area internal doors without using a key. This may cause a delay in responding to an emergency. Staff were aware one key was faulty but it was still in use and had not been reported.

- **Safe staffing**

- The establishment for registered nurses across the site was 20 with 9.8 in post, meaning a vacancy rate of 51%. The target for support workers was 98 with 79 in post leaving a

Vacancy rate of 23%. The provider was mitigating these high vacancy levels by use of regular agency staff. Regular agency staff received the same training and supervision as regular staff.

- We saw on going recruitment efforts by the provider, for example, regular advertisements.

Requires improvement

Child and adolescent mental health wards

- Each ward had the appropriate numbers and skills of staff to ensure the safe staffing of the ward during the day. There were two registered nurses on each ward and between 7 and 10 support workers dependent upon patient assessed need. The figures included increased staffing to support patients on enhanced observations. The ward managers all confirmed they were able to adjust staffing according to clinical need.
- At night there was one registered nurse on each of the three wards, with one senior nurse in charge who worked across the site. The senior nurse would support the team in emergencies and cover staff breaks. This meant that two wards could have a low ratio of registered nurses to patients.
- Some staff reported that at times the wards were left with no registered nurse for a short period. This was when one nurse took a break and the other nurse responded to an emergency or incident on another ward. We raised this with the provider who gave the concern immediate attention to try to prevent this from happening again.
- Patients confirmed that there was sufficient staff for them to have a 1:1 meeting with their named staff.
- Staff and patients both agreed that activities were rarely cancelled due to staffing shortages. Adjustments to times were sometimes negotiated between staff and patients. However, staff recognised as a priority that leave was an essential part of the patient's wellbeing and care.
- We noted that there were at least two occasions where on-call medical staff did not respond to an initiated seclusion within the required one-hour period and on one occasion did not attend at all. There is a requirement for a Dr to review a patient timely following a decision to utilise seclusion to ensure the patients safety and physical wellbeing.
- Staff sickness rates were 6% in February 2017. Although this was over the national average of 5%, it was a reduction in the previous 12 months figures by 4%.
- Mandatory training compliance was high with at least 85% of staff having completed training. The lowest figure was 79% for Level 3 safeguarding (Level 1 Safeguarding was 97% completion) and the highest was 100% for immediate life support and fire warden training.

Assessing and managing risk to patients and staff

- For the period from 19 June 2016 to 19 December 2016 there were 49 episodes of seclusion, ten on Rainforest ward, 25 on Coast ward and 14 on Sky ward.
- Between 19 June 2016 and 19 December 2016 there were 893 restraints used on 52 different patients. There were 1688 restraints in the previous 6-month period between June and December 2105. This was a reduction of 795 restraints. There had been a reduction in bed numbers for part of this period; however, there was evidence of a downward trend in use of restraint. Care plans reflected using other techniques prior to resorting to restraint.
- There were no incidents of prone restraint in the 12-month period up to March 2017.
- Staff were trained in PRICE, which is physical restraints in intensive care in Europe. This was a British Institute of learning disabilities (BILD) accredited, positive behaviour support and physical intervention training course.
- We reviewed 12 patient records and 11 had a risk assessment completed within 24 hours. One not completed until three days after admission. Ten records had evidence of regular update with two records not fully completed.
- Staff did not consistently review and update care plans following a risk incident.
- We saw records of observations in care records. Most of the records were completed and up to date, however on Sky ward we observed staff completing the observations retrospectively. We raised this with the manager who advised the board was kept in the office as it may be used as a weapon. The ward manager said that staff were expected to go to the office every time the board needed completing which could be every 15 minutes. This was not an effective practice of carrying out and recording observations.
- We did not see evidence of the review of supportive observations in clinical records. For instance, one record showed a patients increasing risk but there was no clear plan of how to manage this risk. There was no evidence of review of the patient's observation levels in the ward round held by the Consultant in light of the increased risk. Lack of review of increasing risks could lead to a serious incident.
- There was a daily senior managers meeting where risks were discussed, including discussing patients who were on supportive observations. This did not include a review of the patients observations.

- Staff did not follow their own policy that says there should be a review of patient's supportive observations daily and there should be a daily entry in the patient's clinical notes specifically relating to supportive observations.
- The provider showed us the supportive observation policy. This expired in September 2016.
- Staff received training in the correct searching procedures of patients.
- We saw evidence in patient care plans and clinical notes of efforts to de-escalate prior to the use of restrictive practices such as restraint or seclusion.
- The rapid tranquilisation policy was updated five days prior to inspection but did not reflect the National Institute for Clinical Excellence (NICE) guidance for the administration of rapid tranquilisation medication on young people. The hospitals prescribing of rapid tranquilisation medication was not in line with policy.
- We looked at 37 rapid tranquilisation observation charts. None of the observations were completed in line with policy or best practice. Records kept did not assure us that monitoring was taking place to ensure patients were safe following the administration of rapid tranquilisation. There was no audit of the use of rapid tranquilisation. However, we saw in the governance meeting that there were plans to implement this.
- We noted that there were at least two occasions when on-call medical staff did not respond to an initiated seclusion within the required one-hour period and on one occasion did not attend at all. There is a requirement for a Dr to review a patient timely following a decision to utilise seclusion to ensure the patients safety and physical wellbeing. There was one record where there was no evidence of the nurse calling the doctor and another occasion staff called the doctor who failed to attend.
- Staff maintained sight of the patient during the period of seclusion and recorded observations of the patient every five minutes to help maintain the safety and wellbeing of the patient.
- There was a named child protection lead on site and all staff when asked where familiar with who it was. Everyone asked recognised the types of potential abuse and knew how to escalate and report this information.
- Medicines were stored securely and in accordance with the provider policy and manufacturers' guidance in the small clinic rooms on the wards. The larger clinic room was overstocked and untidy. We noted that several items of stock were out of date. The provider was advised of this.
- There were arrangements in place to enable children to visit with designated rooms on site. There were also facilities to accommodate visitors for a weekend due to the distance travelled by some relatives. There was a risk assessment process in place and if a family visited with a young person then the accommodation would not be shared with another family.

Track record on safety

- The hospital reported 61 serious incidents in the 12-month period up to 1 February 2017. Managers reported a more effective incident reporting system and the recording of incidents. Some did not meet the threshold of serious incidents, but were investigated and reported in the interest of openness, transparency and learning.
- Senior staff reviewed and investigated each incident. Types of incidents included, the high levels of patient violence, self-harm and patients reaching the age of 18 with no suitable adult placement available.

Reporting incidents and learning from when things go wrong

- Staff were fully aware of how to report an incident and what an incident was. Managers reviewed incidents daily at the morning meeting and followed these up if required.
- Emails were sent to staff with lessons learned and there were notices on all the wards called 'Hot Topics' which was an extra reminder of key areas of learning from incidents. There was a folder on the ward for staff to read who did not have easy access to the computer.
- There was evidence of staff debriefs following incidents and the more serious incident debriefs were held by senior staff such as the Clinical Psychologist or Hospital Director. There was limited evidence of patient debrief.

Requires improvement

Child and adolescent mental health wards

Are child and adolescent mental health wards effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- We reviewed 12 care records and 11 had an assessment within 24 hours of admission. Staff completed nursing assessments in 11 out of 12 records with one record partially completed.
- Care records showed that doctors completed physical health care examinations for all 12 patients whose records were examined and there was evidence of ongoing review of these needs.
- Patients accessed the local GP for all aspects of their physical health care. This worked effectively and involved access into the local community. There were systems in place to monitor the effects of mental health medication on site, including ECG's and bloods being taken and reviewed. Staff referred patients for treatment as necessary, for example to dentistry, cardiology and hospital.
- Whilst care plans were up to date and patients reported being involved in the writing of them, the evidence for this was not consistently recorded. For example, Rainforest and Coast patient's records did not always demonstrate patient involvement whereas Sky ward's records clearly showed patient views and involvement. The care plan was not one document and staff had to print off several separate sheets to share with the patient. We saw one patient had eight sheets that formed the care plan.
- We did not see any information in care plans relating to identification of relapse prevention. There was no evidence of identification of early warning signs and triggers to enable staff and patients to manage the potential increased risk at these times.
- The hospital used an electronic system but still held some paper records.

Best practice in treatment and care

- Patients received care and treatment from a range of professionals including nurses, doctors, clinical psychologist and psychology assistants, teachers, occupational therapists and social workers.
- Care plans did not reflect good practice.
- We saw innovative practices such as the use of dogs with the patients. There were three dogs on site each day. The relationship between the patients and animals was evident. The use of the dogs helped patients engage with activities and occasionally worked as a distraction when the patient was at particular risk of self-harm, acting as a companion. All three dogs were involved in motivating the young people to attend school and occupational therapy sessions, as well as supporting the young person in attending review meetings and 1:1 psychology sessions.
- We saw that the occupational therapy assistant had completed a course of camouflage make up. This skill helped patients, who wished to, to cover their scars and walk around with confidence.
- We saw investment in training, particularly around dialectical behaviour therapy (DBT) and positive support plans (PBS). This was in the early stages with a full programme of training taking place for staff to improve the therapeutic skills of all staff. DBT is a type of talking therapy designed to help people suffering from mood disorders as well as those who need to change their pattern of behaviour.
- Clinical psychology input was embedded and the team had expanded to include psychology assistants and access to art therapy. The clinical psychologist was heavily involved in the development of the dialectical behaviour therapy (DBT) training for staff and provided individual staff and group supervision.
- Rainforest ward achieved a participation certificate for the Quality Network for Inpatient CAMHS (QNIC), awarded in October 2016.
- There were strong links with the school, which received a 'good' rating from Ofsted. The school and ward communication was well established and every effort was made to encourage school participation and a variety of courses were available. We saw homework taken to the wards when the children were unable to attend and school was an integral part of the day.
- Staff used the Health of the Nation Outcome Scales (HoNOS) specific to young people to measure clinical outcomes.

Requires improvement

Child and adolescent mental health wards

Skilled staff to deliver care

- There was a range of disciplines and workers providing input to the wards, which included clinical psychology, occupational therapists, nurses, support workers, doctors, psychology assistants, social worker and art therapist.
- All staff had undergone a Disclosure and Barring Service (DBS) check and were checked against the Protection of Children Act (POCA) prior to appointment.
- There was an induction programme in place for new staff and support workers started the care certificate as part of their induction.
- We saw supervision took place, however some staff did not feel they received sufficient supervision. For instance, staff had group supervision. One staff member we spoke with had not received 1:1 supervision for three months. Supervision figures were over 80% for the wards.
- Annual appraisals where carried out, however compliance was 72%.
- There were a number of training opportunities for all levels of staff. The training ranged from short courses such as dialectical behaviour therapy (DBT) to clinically based masters degrees and leadership courses.

Multi-disciplinary and inter-agency team work

- There where regular multidisciplinary team meeting held involving the patient and carers were appropriate.
- The care plans did not reflect multidisciplinary team goals.
- Staff carried out handovers using a handover folder which covered the urgently required information. We reviewed the information which was brief and informative including actions to be followed up. The school also engaged with handover and there was effective communication between the school and wards.
- The hospital had created an internal care coordinator role. Staff with this role would be the key people to ensure that other professionals, families and looked after children authorities had the appropriate information.
- The social worker who was the children's safeguarding lead had established links with the individual patient's local authority.

Adherence to the MHA and the MHA Code of Practice

- Ninety two percent of staff had completed MHA training.
- The provider carried out regular audit of seclusion and we saw that the provider was identifying and sharing lessons. We saw evidence on the ward of lessons learned being cascaded to the wards by senior managers along with an email sent to all staff. The staff on the wards had not followed all this guidance. The provider did not have a system in place to ensure lessons learned were put into practice.
- We reviewed the records of one patient who had been in long-term segregation. There was clear evidence of rationale for the decision via a multi-disciplinary team. However, there were gaps in the process with no record of a safeguarding referral, nor a referral to the independent mental health advocate. There was no record of where the segregation took place, or plans for the patient to access fresh air, activities or meals.
- The seclusion care plans we saw did not meet the recommendations of the code of practice. For instance there was no statement of clinical need, no plan as to how needs were to be met nor details of family, carer or parental responsibility communication would be met. The review of paperwork following the period of seclusion included some of the information retrospectively.
- Staff did not routinely assess the children and young people's capacity/competence and record consent status with regard to treatment within the first three months of their treatment for mental disorder as per the code of practice 24.41.
- The Consultants were not updating consent when a patients medication had changed on the consent to treatment form known as a T2. The form, which is signed by the Consultant, says that the patient has consented to the prescribed treatment. This means that when medication had changed the form was not updated so the patient may not have consented to that change. We saw this in three records reviewed.
- Staff read 12 of the 13 patients' rights on admission to hospital. Staff did not read the thirteenth patients' rights until one month into admission.
- Staff did not meet their own policy of reading rights on a weekly basis; however, this is under review by the provider. Records showed further reading of rights were between 2 and 6 weeks.
- All patients on site were detained under the MHA with the exception of one. Staff had advised this patient of their rights as an informal patient and the hospital was

looking urgently for a bed in an open setting, as all wards at Huntercombe are secure. At the time of inspection, the patient had been on the ward as an informal patient for 5 days following tribunal decision to remove the section.

- Patients were advised of their right to appeal against the section and how to do this and we saw evidence of hearings and referrals to tribunal in accordance with the patients statutory rights.
- Section 17 leave forms were up to date, reviewed regularly and completed accurately. Staff did not offer families copies of Section 17 leave arrangements, which is against the MHA code of practice guidance 27.22.
- Staff did not record clearly in patient records who had parental responsibility.
- The MHA administrator completed regular audits to ensure that MHA paperwork was completed correctly.
- Three staff spoken to were not clear about the role of the independent mental health advocate (IMHA). Staff did not automatically refer patients who did not have the ability to decide whether or not to engage an IMHA to the service as per the MHA code of practice 6.16 and 19.107. It was not clear from patients notes whether any patients had been referred to the IMHA.
- We checked seclusion records and we found that out of nine checked, seven were not completed in line with the MHA code of practice.

Good practice in applying the MCA

- Staff completed mandatory Mental Capacity Act (MCA) training which included Gillick competence (for children under the age of 16, the young person's decision-making ability is governed by Gillick competence. The concept of Gillick competence recognises that some children may have sufficient maturity to make some decisions for themselves). Training completion compliance was 92%.
- We found a mixed ability of understanding of the Gillick competence by staff. Some staff interviewed were familiar with this process whilst others, including registered nurses, where not. We found in two records that a doctor had assessed a young person under 16 using the Mental Capacity Act, which was incorrect.
- Children did not have their competency/capacity assessed and their consent recorded with regard to treatment within the first three months of treatment.
- Senior managers were aware of areas for development and we saw a plan to improve staff knowledge and understanding of capacity/competency and consent.

Are child and adolescent mental health wards caring?

Good

Kindness, dignity, respect and support

- We observed interaction between patients and staff. We found that staff responded in a caring, non-judgemental and kind manner at all times and occasionally in difficult circumstances such as when patients were displaying behaviours that were challenging.
- Patients reported that staff were very kind, one even saying the staff were too kind. One patient said it was 100% better than their last placement. Two commented they felt looked after and cared for.
- Staff had a good understanding of patient's needs, knew the individual patients and their likes, dislikes, care plans and risks.

Staff supported patients to attend activities off the ward based on individual risk assessment.

The involvement of people in the care they receive

- We saw a comprehensive welcome pack providing useful information required when patients were admitted to the hospital.
- Patients spoke of being involved in their care plans although staff did not record this consistently in the clinical records. We saw patients were offered a copy of their care plan and were invited to attend and contribute at their care reviews.
- Where appropriate, families were invited to attend care reviews.
- There was a general advocate based on site three times a week.
- We spoke to two carers. They were very positive about the care their child had received. They used words like 'I got my child back' and 'staff went the extra mile'. They received weekly updates via the clinical psychologist. One carer said that there was an opportunity to move their child closer to home but they were so satisfied with the care that they decided not to make the move.

Requires improvement

Child and adolescent mental health wards

- There was accommodation for up to two families so those traveling a long way could stay over free of charge.
- The hospital had introduced a new initiative called #pizza chat. This gave the patients a forum to discuss issues important to them.

Are child and adolescent mental health wards responsive to people's needs? (for example, to feedback?)

Good

Access and discharge

- The average bed occupancy on the wards was 83% on Coast ward, Rainforest was 89% and Sky was 59%, between the period 1 June 2016 and 30 November 2016.
- Referrals were accepted from anywhere in the country.
- There were three occasions of delayed discharge due to the patient turning 18 years old with no bed identified for transfer. The provider advised the local area in advance of the patients' birthday and the provider organised discharge planning meetings, however the local commissioners had not identified a suitable placement. in a timely manner.
- Patients transferred between wards on occasion, if there was a clinical need and benefit to the patient. Patients occasionally moved rooms within the ward, for example, to ensure mixed sex guidance was met or for safeguarding concerns.

The facilities promote recovery, comfort, dignity and confidentiality

- There was a range of rooms and equipment to support treatment and care. For example, small clinic rooms on the wards, activity rooms, quiet areas, visitor's rooms and therapy rooms.
- Patients were able to make private phone calls unless risk assessed otherwise.
- Drinks were available 24 hrs a day with snacks available at set times and upon request. Patients had their own snack boxes kept in the small kitchen on the ward.
- Bedrooms were personalised, patients were able to put posters on their walls. Recently, patients had been involved in making decisions on colour schemes in bedrooms.
- There was secure space for personal possessions in the bedrooms although most young people did not have a key due to individual risk assessments.
- The young people's educational needs were met onsite with a school located close by in the grounds of the hospital. The school was rated as 'good' following the Ofsted inspection in June 2016 with personal development, behaviour and welfare rated as 'outstanding'. We saw teachers providing work to do on the wards when the young person was unable to attend school and there were strong links between services ensuring effective communication.
- There was a programme of weekly activities with occupational therapist input seven days per week. Staff supported activities off site where section 17 permitted. There was a timetable of events for young people to engage in planning and delivering, such as Red Nose day events and other special days.

Meeting the needs of all people who use the service

- The hospital did not have facilities to provide care and treatment for patients with a significant physical disability.
- There were no information leaflets available to patients about physical health, mental health or health promotion.
- There was information on MHA rights and access to advocacy available. Combine these points.
- Staff told us that information could be translated into other languages if needed.
- There was access to spiritual support and there was a multi-faith room on site, which patients accessed when they requested. Patients received culturally and spiritually relevant dietary needs.

Listening to and learning from concerns and complaints

- For the 12-month period up to November 2016 there were 40 complaints on Coast ward with five upheld. There were 23 complaints on Rainforest ward with six upheld and 45 complaints on Sky ward with 11 upheld. All complaints were resolved locally. The provider did not give detail on any trends or themes from the complaints raised. There were no complaints raised with the ombudsman.

Requires improvement

Child and adolescent mental health wards

- Each ward had a welcome pack for patients with a range of information to assist with the initial admission. The complaints procedure was explained in the pack and forms were available for patients on the ward.
- We saw that staff responded to patients concerns and complaints swiftly and a senior manager sent letters as part of the response, which included any action taken where appropriate.
- We saw that staff discussed complaints at the staff meeting but there was no evidence of what lessons were learned. The minutes concentrated on the number of complaints opposed to the nature of the complaint.

Are child and adolescent mental health wards well-led?

Requires improvement

Vision and values

- Some staff did not know what the organisation's vision and values were. However, staff used words such as person centred, responsive, caring and excellent when describing values they held as integral to their practices.
- Senior managers visited the ward and staff spoke highly of the hospital director.

Good governance

- We found that management and governance systems in place were appropriate for senior staff to determine the strengths and development needs of the organisation. We saw evidence of management information such as attendance of staff at mandatory training and supervision engagement and appraisal completion.
- Attendance of Mental Health Act and Mental Capacity Act training was high. However, this did not appear to improve compliance in certain areas, for instance, capacity and consent.
- Senior managers recognised the amount of work required to improve the safety and care of patients. Following a serious incident, there was a review of care plans, risk assessments and observations with changes made to improve compliance in these areas. This was added to the audit programme.
- Systems were in place for the provider to learn from incidents, complaints and ensure there was patient and staff feedback from surveys.
- Ward managers moved wards to try to cover shortfalls. This left a lack of direct leadership to front line staff.
- While there was management information available to ward based managers, there was no monitoring system in place to ensure that this was being understood or followed by ward based staff.
- There was no audit of supportive observation or of rapid tranquilisation. The provider did not identify concerns relating to these areas. However, we saw some clinical audits with plans in place for improvement to clinical practice to address any identified concerns in response to audit outcomes.
- Monthly local clinical governance meetings and senior management team meetings took place. Agenda items included audits, updates to the local risk register, environmental concerns, safe staffing and patient care.
- Policies were not all up to date. For instance, the supportive observations policy was due for review in September 2016.
- There was a detailed risk register, which managers reviewed monthly at both the senior management team meetings and local clinical governance group meetings.
- Front line staff were not aware that they could add items to the provider's risk register and had limited knowledge of what the risks were currently on the register.

Leadership, morale and staff engagement

- Sickness rates varied from month to month, however the average for February 2017 was six percent, which was a four percent reduction from the previous February 2016 and was closer to the national average of five percent.
- There were no cases of bullying or harassment and staff felt able to raise concerns without fear of victimisation.
- Front line staff knew the senior management team and spoke highly of the hospital director in particular and the management team as a whole.
- Ward managers felt supported and said they had sufficient authority to make prompt changes when needed.
- Staff had opportunity to access further courses for their own professional development. We saw a range of courses, such as a Masters course in therapeutic interventions, leadership courses and the care certificate. There was physical healthcare training such as phlebotomy and ECG recording available. Staff felt supported to improve their skills and knowledge.

Requires improvement

Child and adolescent mental health wards

- Staff understood the need for openness and transparency and would acknowledge when things went wrong. The provider had not delivered training regarding duty of candour responsibilities

Commitment to quality improvement and innovation

- Rainforest ward had a certificate of recognition of participation in the Royal College of Psychiatrists' Quality Network for Inpatients (Child and Adolescents).
- The provider had developed their occupational therapy and psychology services with new initiatives introduced.
- Staff were in the process of receiving training in dialectical behaviour therapy (DBT) skills to improve the quality of interactions with patients.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure there are registered nursing staff on the ward at all times.
- The provider must ensure that staff monitor and record the physical health of patients who have received rapid tranquillisation.
- The provider must ensure that patients capacity/ competency is assessed and documented upon admission and throughout treatment as necessary.
- The provider must ensure that patients are referred to an independent mental health advocate when necessary.
- The provider must ensure that episodes of seclusion are recorded clearly.
- The provider must ensure that the Mental Health Act Code of Practice (2015) is adhered to in respect of caring for patients in long-term segregation.
- The provider must ensure the enhanced supportive observation policy is up to date and staff must follow best practice in observations.
- The provider must ensure that accommodation meets the mixed sex guidance within the mental health act code of practice.
- The provider must ensure care plans are reviewed and updated based upon changes to assessed risk.

Action the provider SHOULD take to improve

- The provider should review the lines of sight on the wards with a view to ensuring the safety of patients and staff at all times.
- The provider should ensure that staff on all wards have a clear understanding of the Mental Capacity Act 2005, how to assess competence of children under the age of 16, and the implications for their practice.
- The provider should ensure that all medicine stocks are stored appropriately and the manufacturer's expiry dates checked regularly.
- The provider should ensure all staff receive an appraisal each year.
- The provider should ensure that all of their policies are reviewed and updated regularly.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • Patient's physical health was not monitored following the administration of rapid tranquilisation medication. • Medical prescribing of rapid tranquilisation did not meet the provider's own policy. • Care plans were not always reviewed and updated following an identified change to risk. • Supportive observation levels were not reviewed as per policy, for instance they were not reviewed daily nor were they reviewed for each patient following increased risk. • The supportive observation policy was not reviewed and was out of date. • Accommodation did not meet the mental health act code of practice for mixed sex guidance. This was a breach of regulation 12

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

- The provider did not comply with all the policy and practice to meet the requirements set out in the Mental Health Act code of practice

This was a breach of regulation 17

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing • The provider did not ensure that the wards were staffed by a trained nurse at all times. This was a breach of regulation 18