Cambian - The Willows

Quality Report

Fritton End Road
Gorefield
Wisbech
Cambridgeshire
PE13 4NQ
Tel:01945 871491
Website: www.cambiangroup.com

Date of inspection visit: 8 March 2016
Date of publication: 28/06/2016

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	Good
Are services safe?	Good
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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.

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.

Summary of findings

Overall summary

We rated Cambian – The Willows as good because:

- Risk assessment and risk management plans were of good quality, consistent and reviewed regularly.
- Staff had a good understanding of the different levels of observation necessary to keep patients safe. They followed the hospital's policy and documented observations appropriately.
- The service complied with local safeguarding children board procedures and appropriate national guidance. Staff were knowledgeable about safeguarding patients from abuse and had access to safeguarding leads for further guidance.
- Staff completed a comprehensive assessment of the patients' needs in a timely manner. They held formulation meetings with families and other agencies to develop up to date, personalised recovery focused care plans.
- The service used best practice guidance to improve patients' self-esteem and confidence and promoted the use of diversionary activities.
- The service manager and clinical lead supported staff, who received regular clinical and managerial supervision. Staff had an annual appraisal of their work performance and were able to contribute with suggestions.
- The multi-disciplinary team (MDT) introduced a ward round book. This encouraged patients to write down what they wanted to discuss but did not feel confident to say in person.
- Staff treated patients with kindness, respect and compassion. They participated in activities and interacted at an appropriate level.
- The service had a clear admissions policy, taking into account the current mix of patients before accepting new admissions, to prevent the recovery of existing patients from being compromised. Staff devised a weekly activity plan offering a range of therapeutic pursuits, with activities provided by external organisations. These included local animal centres and specialised art therapy centres.
- The service provided meals that met patients' specific dietary requirements. The catering team took into account culture, individual preferences and allergies when producing menus and provided clear information about the ingredients used in each dish.
- The service had a clear organisational governance structure and used key performance indicators to monitor service performance.

However:

- The provider's Mental Health Act (MHA) policy was not up to date following changes made to the code of practice in April 2015.
- Staff compliance with mandatory MHA and Mental Capacity Act (MCA) training was 55%. We were not assured this training included the MHA revised code of practice.
- The service was not always able to accommodate external activities on a one to one basis.
- Action plans developed from feedback obtained from patients' contained actions carried over from one plan to another with no end date.

Summary of findings

Contents

Summary of this inspection

Page

Background to Cambian - The Willows 5

Our inspection team 5

Why we carried out this inspection 5

How we carried out this inspection 5

What people who use the service say 6

The five questions we ask about services and what we found 7

Detailed findings from this inspection

Mental Health Act responsibilities 9

Mental Capacity Act and Deprivation of Liberty Safeguards 9

Overview of ratings 9

Outstanding practice 18

Areas for improvement 18

Action we have told the provider to take 19

Good

Cambian - The Willows

Services we looked at

Child and adolescent mental health wards.

Summary of this inspection

Background to Cambian - The Willows

Cambian - The Willows is a 14 bedded mixed gender inpatient service for patients aged between 12 and 18. It provides care and treatment to patients in crisis who are experiencing mental health issues. At the time of the inspection, two patients were detained under the Mental Health Act (MHA) 1983. In total the service had 12 patients admitted, two of whom were on leave. Patients were either admitted to the unit informally or detained under the MHA.

Cambian Group provides the service from a stand-alone unit located in the rural village of Gorefield, which is approximately four miles from the nearest town of Wisbech. The service provides a teacher to work with those patients who are not well enough to attend the nearby education facility.

The Willows has a registered manager. A registered manager is a person who is registered with the Care Quality Commission (CQC) to manage the service. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations.

The service is registered to carry out the following regulated activities:

- assessment or medical treatment for persons detained under the Mental Health Act 1983
- treatment of disease, disorder and injury

The CQC previously inspected Cambian – The Willows on 04 July 2013. Concerns identified during this visit have since been addressed and the service was compliant. A Mental Health Act reviewer inspected the service in November 2015 and found the service needed to look at improving its practice regarding the locked door policy for informal patients. This is the first inspection of Cambian – The Willows using the CQC's current methodology.

Our inspection team

Team leader: Jacqui Holmes

The team that inspected the service comprised two CQC inspectors and a specialist Child and Adolescent Mental Health Service (CAMHS) nurse.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme.

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 visit, we reviewed information that we held about the location.

During the inspection visit, the inspection team:

- visited the service, looked at the quality of the environment and observed how staff were caring for patients

Summary of this inspection

- spoke with one patient and one carer who were using the service
- interviewed the registered manager
- met with nine other staff members including doctors, nurses, a psychologist, a psychologist assistant, an occupational therapist assistant, a social worker and a chef
- attended one hand-over meeting and one multi-disciplinary meeting
- observed three group activities involving patients and staff
- reviewed in detail eight care and treatment records of patients
- carried out a specific check of the medication management on the ward
- Reviewed policies, procedures and other documents relating to the running of the service.

What people who use the service say

We looked at feedback from patients' following a service survey in December 2015. Fourteen out of sixteen patients commented that staff treated them with politeness and respect.

We spoke with a patient who said they felt safe at the service and staff looked after them well. A parent thought the unit was better than any other their relative had been in previously. The only negative comment received was about staff availability, as external activities did not always take place.

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?

Good

We rated safe as **good** because:

- The premises were clean and well maintained.
- There were sufficient staff to ensure the safety of patients.
- Risk assessment and management plans were of good quality, consistent and reviewed regularly.
- Staff maintained the clinic room to a good standard, and carried out the necessary checks on clinical equipment and medications.
- Staff were knowledgeable about safeguarding patients from abuse and had access to safeguarding leads for further guidance.
- Staff achieved good compliance rates with mandatory training and had access to a range of other specialist training.
- There was an established system for reporting and learning from incidents.

Are services effective?

Requires improvement

We rated effective as **requires improvement** because:

- The organisation had not updated its policy on the Mental Health Act (MHA) following changes to the code of practice in April 2015.

However:

- Staff carried out comprehensive assessments of the patient's needs in a timely manner.
- Patients' had up to date, personalised and recovery focused care plans.
- Staff followed appropriate best practice guidance.
- Staff had the necessary skills and training to provide care and treatment.

Are services caring?

Good

We rated caring as **good** because:

- Staff were kind, respectful and compassionate. They interacted and communicated in an age-appropriate way.
- The service worked closely with families and other agencies to provide holistic care and treatment.
- Staff from the multi-disciplinary team attended community meetings, activity planning sessions and a breakfast club to nurture therapeutic relationships and breakdown barriers.

Summary of this inspection

However:

- Action plans developed from feedback obtained from patients' contained actions carried over from one plan to another with no end dates.

Are services responsive?

Good

We rated responsive as **good** because:

- The service had a clear admissions policy, taking into account the current mix of patients before accepting new admissions.
- The service held a weekly meeting giving patients the chance to plan activities they would like to do later in the week.
- The catering team produced menus that met patients specific dietary requirements.

Are services well-led?

Good

We rated well-led as **good** because:

- The service had a clear organisational governance structure.
- The organisation, manager and staff used key performance indicators to monitor the service's performance. Staff had an annual appraisal of their work performance and regular clinical and managerial supervision
- Staff felt supported by their colleagues, the manager and the organisation.
- Staff had opportunities to give feedback on the service or raise concerns without fear of victimisation.

Detailed findings from this inspection

Mental Health Act responsibilities

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

The organisation had not updated its policy on the MHA following changes to the code of practice in April 2015.

The service had two patients detained under the MHA. Staff regularly explained to them their rights under section 132 and recorded their understanding.

Patients were receiving treatment authorised by the appropriate certificate. We saw that copies of the certificates were stored with their prescription cards. In each case, an assessment of capacity to consent to the treatment had been recorded.

Administrative support and legal advice on implementation of the MHA and its code of practice were available from a central team. The team carried out audits twice yearly to ensure the correct application of the MHA.

The Willows used an advocacy service and all patients engaged with an advocate.

Mental Capacity Act and Deprivation of Liberty Safeguards

The Mental Capacity Act (MCA) and its principles apply to those patients aged 16 and over who were treated informally rather than detained under the MHA 1983.

We saw patients' notes showed capacity assessments completed by the doctor and that best interest meeting were held.

The staff were familiar with the principles of Gillick competence that for children under the age of 16, their 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). In many cases this did not apply as the patients admitted to the service were experiencing mental health issues and in crisis.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Child and adolescent mental health wards	Good	Requires improvement	Good	Good	Good	Good
Overall	Good	Requires improvement	Good	Good	Good	Good

Good

Child and adolescent mental health wards

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

Are child and adolescent mental health wards safe?

Good

Safe and clean environment

The Willows was clean with well-maintained furnishings, décor and equipment. Cleaning records were up to date and showed housekeeping staff regularly cleaned the environment and had systems in place to reduce the risk and spread of infection. Maintenance and housekeeping staff attended a daily meeting to discuss any areas of concerns or maintenance work requiring attention. An environmental risk assessment was undertaken annually and was in date. A recent patient survey showed 15 out of 16 patients were positive about their environment and living conditions, and 13 out of 16 thought the standard of cleanliness was good. The kitchen had a food hygiene rating of 5 stars awarded by the Food Standards Agency, which meant food hygiene standards were good.

Staff did not have clear lines of sight to all areas due to the layout of the building, which covered two floors. The service had convex mirrors placed along corridors to enable staff to observe patients in areas where there were blind spots. The majority of patients' bedrooms were located on the first floor. Doors to patients' bedrooms had viewing panels fitted, which allowed staff to observe patients' safety and monitor risks. Staff carried personal alarms and there were call bells in patients' rooms to summon assistance if required. Staff we spoke with knew how to respond when alarms activated. A qualified nurse was present in the communal area of the ward at all times.

The service had an annual ligature risk audit that was in date (Ligature risks are fittings to which patients intent on self-injury might tie something to harm themselves). This clearly identified risks and included an action plan to minimise them. Staff we spoke with knew how to manage these risks in order to keep the patients safe. However, the audit did not identify the sliding windows in patients' bedrooms as a ligature risk and we discussed this with the manager to action

All patients' bedrooms were ensuite and grouped by gender to achieve separate sleeping arrangements for male and female. This allowed the unit to meet the Mental Health Act (MHA) code of practice on same sex accommodation.

The service had a fully equipped clinic room, which was clean and well organised. We saw staff carried out the necessary clinical checks for fridge temperatures, controlled drugs, stock medication and medical equipment. They checked emergency drugs and resuscitation equipment regularly and ensured that any drugs requiring disposal took place. We noted nurses did not hold the keys to the controlled drugs cupboard separately from other keys. Cambian policy stated the keys must be held separately. Staff had addressed this issue by the end of our visit.

Safe staffing

The provider had reviewed staffing levels in the last year using the 'Child and Adolescent Mental Health Service (CAMHS) Quality Network for inpatient (QNIC) as guidance. The service operated a day shift pattern of two qualified

nurses and seven support workers, and one qualified nurse and between five and seven support workers for the night shift. Depending on patients' needs, the service also included a twilight shift nurse or support worker.

The service employed eight qualified whole time equivalent nurses and 26 support workers. At the time of the inspection, there was one nurse vacancy and two support worker vacancies. In the last three months, the service had filled all shifts, using bank staff to cover sickness, absence or vacancies. The Willows used bank staff that were familiar with the service and the patients. Staff sickness rate from January 2015 to December 2015 was 7.3% and staff turnover for the same period was high at 29.5%. The manager and staff we interviewed said new staff were affected by patients' behaviour and the challenges these presented, which led to the high turnover rate.

The ward manager was able to increase the number of staff on duty by accessing support workers from a nearby children's home run by the same provider. If qualified nurses were needed bank staff were used. All patients had weekly one to one sessions with their named nurse. In addition, all patients had a named key worker, such as an occupational therapy assistant (OTA), to support them.

There was enough staff for group-escorted leave to take place although it was sometimes difficult for the service to facilitate one to one escorted leave and outside activities. Staffing levels were safe and sufficient to accommodate observation levels, hospital appointments and therapeutic activities.

The service had adequate medical cover with a psychiatrist able to attend immediately during the day. Out of hours, the service had access to the on call psychiatrist. Staff were available to drive patients to hospital appointments and contacted emergency services for physical health needs if appropriate.

All staff received mandatory training, which included emergency life support training.

The provider had a target compliance rate of 85%. The service was currently achieving 97.4% apart from Mental Capacity Act (MCA) training, which was 44%. However, they expected to be compliant with the target by the end of March 2016 as all staff who had not undertaken the training were booked on a course.

Assessing and managing risk to children and young people and staff

We looked at eight patients' care records in detail. We saw staff had completed risk assessments during the admission process. Risk assessments covered a range of areas including present and historic risk factors. Staff formulated risk management plans from the assessment information. Nurses updated risks daily and the psychologist updated patients' risk assessments weekly. This meant the service managed risks safely and effectively.

The service had house rules and expectations designed to keep their patients safe. Staff informed patients and their families what items were restricted, for example, alcohol, drugs, razors and weapons. There were policies and procedures for use of observation (including minimising risk from ligature points -fittings to which patients intent on self-injury might tie something to harm themselves) and searching patients. Staff followed the observation policy, showed an understanding of the different levels of observations undertaken and documentation required. They reviewed observation levels daily. Patients did not have access to their bedrooms during the day unless supervised by staff. This encouraged patients to attend education and activity sessions and establish a normal daytime routine.

We saw staff successfully divert a patient who was getting bored and disruptive using distraction techniques. They also used the sensory room and medication prescribed as needed to de-escalate challenging situations. Staff had all been trained in managing violence and aggression and told us they were confident in managing aggression using the correct techniques. Staff only used restraint after de-escalation had failed (restraint refers to direct physical contact where the intervener's intention is to prevent, restrict, or subdue movement of the body, or part of the body of another person). Staff used restraint to prevent patients from self-harming behaviour. There were 118 incidents of restraint recorded in the six-month period ending December 2015. Staff did not carry out prone restraint (prone restraint is being held chest down, with face down or to the side). The Willows did not use seclusion and had no incidents of long-term segregation. The service recorded nine incidents of rapid tranquilisation in the 12 months prior to the inspection. Staff followed the provider's policy and guidance for monitoring physical observations on these occasions.

Good

Child and adolescent mental health wards

The service had four safeguarding leads who had received training to an advanced level in safeguarding. These included the service manager, clinical lead, social worker and consultant psychiatrist. This meant that a safeguarding lead was always available to advise staff about concerns. All staff spoke confidently about how and when they would make a safeguarding referral. We saw from the safeguarding records that staff had raised nine alerts in the last year. The Willows had a good relationship with local police and safeguarding authorities. The service complied with local safeguarding children board procedures and appropriate national guidance. The social worker at the service worked with local authorities and notified them when a patient remained there for a consecutive period of three months. This was in line with section 85 of the Children Act 1989. All staff employed had undergone enhanced disclosure and barring service checks. They received and were compliant with safeguarding training.

The Willows had procedures and systems in place to facilitate medicines management practice.

Track record on safety

There had been five serious incidents at The Willows in the 12 months prior to the inspection. These incidents included setting fire to a room, absconding, an attempted overdose while on leave, lack of a suitable placement and injuring a nurse during a restraint. This incident was reported under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013.

Reporting incidents and learning from when things go wrong

All staff knew how and what to report as an incident. During February 2016, staff reported 89 incidents: 68 related to self-harm, 20 to violence and aggression and one to a patient absconding. The service manager reviewed the incidents and prepared a bi monthly report for the Cambian board. Staff received feedback following investigation into incidents either at team meetings or during supervision.

Investigations into serious incidents led to improvements in safety. For example, staff had not found a concealed lighter during a routine pat down search. This led to staff discussing banned items with parents as well as patients.

Staff we spoke with told us they had received debriefs following serious incidents. They had a 'hot' debrief immediately following an incident to talk about how they managed the incident. A 'cold' debrief took place a week later and was more reflective in nature, looking at lessons learned and what could be done better. The multi-disciplinary team also offered staff individual debriefs and informal discussions during ward rounds.

Are child and adolescent mental health wards effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

We reviewed eight patients' records and found staff completed comprehensive and timely assessment of the individual's treatment needs. We saw the staff assessed the patients for their mental and physical health needs and social care needs. Staff indexed each record for ease of use, with clear sections for each aspect of care and treatment.

A formulation meeting took place within seven to ten days of admission. All patients had psychology assessments shortly after admission. The psychologist used the 'quality network for inpatient child and adolescent mental health service (CAMHS)' baseline assessment tools appropriate to their needs. This included the goal based, brief behaviour screening strengths and difficulties questionnaire,

The occupational therapist (OT) assessed daily living skills during a one to one meeting with each patient and planned activities to meet individual needs.

We saw evidence that physical health examinations had been undertaken and there was ongoing monitoring of physical health problems, as well as nutritional risk assessments depending on need.

Care plans were up to date, personalised and recovery-oriented. Staff developed care plans in conjunction with the patients, which included a therapeutic programme and an interest checklist. We noted three out of the 12 patients' had not signed to say they had received a copy of their care plan.

The service held medical and care records in paper format, which was stored securely in a locked office. When staff used electronic systems, they scanned the information and sent it by email, password protected.

Best practice in treatment and care

The medical team prescribed medicines in accordance with the National Institute for Health and Care Excellence (NICE) guidance. For example, the service followed NICE guidelines on depression in children and young people, social anxiety disorders, phobias, obsessive-compulsive disorder, managing violence and aggression specific to child and mental health services and self-harm. Each patient also had a protocol for the use of 'as required' medication.

Patients had access to appropriate psychological therapies, for example, mindfulness and counselling. We observed a mindfulness group with staff and four patients, which practised deep breathing and focused on emotions management. It was difficult to provide a set cognitive based therapeutic package for patients, as their stay on the ward was short. Instead, the service focused on their present needs and provided individualised treatment plans. For example, the OT provided activities designed to build confidence and help with concentration and low mood.

The service used several recognised rating scales depending on needs and presentation. Staff assessed patients' using the health of the nation outcome scales. This covered 12 key health and social areas and helped clinicians to see how the patients responded to interventions over time. They also used a recognised scale for assessing attention deficit hyperactivity disorder.

Staff carried out a variety of clinical audits to monitor how the service was performing. These included clinical records, and a monthly medication card audit.

Skilled staff to deliver care

A full range of experienced and qualified mental health disciplines and workers provided input to patients' care and treatment. The service employed a clinical lead, a clinical psychiatrist, a consultant locum registrar, a psychologist and a psychology assistant, an occupational therapist and occupational therapy assistants, registered mental health nurses, support workers, a service manager and a social worker. In addition, they also employed administrative, catering, maintenance and housekeeping staff. The service had access to a speech and language therapist if needed. Pharmacist input was through a local pharmacy contract.

Clinical supervision took place monthly and case management supervision every six weeks, this followed Cambian policy requirements. All staff received, and were up to date with annual appraisals. This meant staff had clear goals and objectives, which their manager reviewed regularly. This allowed the manager to identify improvements and assess the quality of care staff provided.

There were monthly team meeting minutes that addressed issues including incidents, complaints, and safeguarding.

The service encouraged staff to undertake specialist training relating to their role. The clinical lead was currently taking a non-medical prescribing course and four support workers had their applications approved to take a national vocational qualification level three in healthcare.

The provider had systems and procedures in place for addressing staff performance issues. We saw evidence that the service manager dealt with performance issues in a timely and efficient manner.

Multi-disciplinary and inter-agency team work

The morning handover took place before, and fed into the daily multi-disciplinary team (MDT) meeting. The MDT meeting was held to discuss patients, staffing issues, the environment and plans for that day. The first half of the meeting included representatives from all disciplines employed by the service. They discussed daily requirements and specific housekeeping and maintenance items. During the second half of the meeting, health and social care professionals discussed patients focusing on presentation, risks, developments and plans. This ensured staff had up to date information on a daily basis.

We observed strong working relationship between members of the team during a multi-disciplinary team ward round. These took place weekly, with patients attending their fortnightly review. Relatives/carers also attended if they were able to. The ward round was attended by the manager, a nurse, key worker, a psychiatrist, a registrars, a psychologist and administrative

support. If required, an advocate would also attend. Discussion focussed around level of observation, section 17 leave, medication, risk management and family involvement.

The service had well developed interagency partnerships, maintaining contact with referring children and adolescent mental health services (CAMHS) community teams. Community teams attended a formulation meeting either in person or by teleconference due to the rural location of the service. Health care professionals and those with parental responsibility discussed the needs of the patients' at the formulation meeting. This formed the basis of the treatment plan.

Contact with the community teams was encouraged and this often took place when the patients were on leave for practical reasons. Patients had scheduled care programme approach meetings. The service invited everyone involved in their care to attend either in person or by teleconference. Occasionally staff from the service travelled to the patients' area to facilitate a meeting with the community team. This strengthened their professional relationship and ensured the needs of patients' were met. The social worker had good links with social services and local authorities.

Adherence to the Mental Health Act (MHA) and the MHA Code of Practice

The mandatory training figures supplied by the service, showed the MHA, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards DoLS as being one training package. The compliance rate with this training was 56%. Staff who had not yet received this training were booked onto a training course before the end of March 2016. The provider expected nurses to keep up to date with the MHA as part of their nursing registration. Staff we spoke with who had received the training focused more on the MCA than MHA.

The corporate MHA policy was not up to date. The provider had not reviewed the policy since April 2013 despite the MHA Code of Practice changes in 2015. The MHA administrator for the unit was aware of changes to the code of practice, however, we were not assured that the service had fully implemented or that staff had received additional training in the revised Code of Practice.

At the time of our visit, the service had two patients detained under the MHA. Staff had attached the appropriate consent to treatment forms to their medicine cards. This meant staff had discussed their medication with them and explained why they were taking it.

Patients had their rights under the MHA explained to them on admission and weekly thereafter. Staff documented this in the patients' care plans.

Administrative support and legal advice on implementation of the MHA and its code of practice was available from a central team.

Detention paperwork was up to date, filed and stored appropriately in an easy to identify folder.

The provider audited their MHA files twice a year to ensure staff applied the MHA correctly.

Patients had access to the independent mental health advocacy (IMHA) services. Staff knew how to access and support engagement with the IMHA. The advocate service was available once a week.

A dedicated mental health information board in the dining room contained advocacy leaflets advising patients of their service and leaflets explaining patients' rights under the MHA.

Good practice in applying the Mental Capacity Act (MCA)

The MCA and its principles apply to those patients aged 16 and over who were treated informally rather than detained under the MHA 1983.

Training in the MCA was mandatory. Staff who had not completed this training were expected to be compliant before the end of March 2016. The MCA does not apply to patients aged 16 or under.

For children under the age of 16, their decision making ability is governed by Gillick competence. The concept of Gillick competence recognises that some children under the age of 16 may have sufficient maturity to make some decisions for themselves. The staff we spoke with were familiar with the principles of Gillick competence. In many cases this did not apply as the patients admitted to the service were experiencing mental health issues and in crisis.

Good

Child and adolescent mental health wards

We saw patients' notes showed capacity assessments completed by the doctor and that best interest meetings were held.

Are child and adolescent mental health wards caring?

Good

Kindness, dignity, respect and support

Staff treated patients in a kind and respectful way. They were sensitive to their needs and showed a good knowledge of the issues faced. During the multi-disciplinary team ward round, we observed very good interactions with patients and saw staff were compassionate and caring towards them.

We observed three group activities and found staff friendly and approachable, encouraging the patients to join in the activities. We noted joint participation between staff and patients during these activities.

The involvement of people in the care they receive

Staff described the admission process on the ward. They introduced the patients to the environment and gave them guidance about house rules and information about treatments contained in a welcome pack.

Patients contributed to their care plan if they could. Staff reported that they tried to write care plans collaboratively with patients but that this could be difficult at times. They explained the progress and treatment plan in weekly one to one sessions. Records showed nine out of the twelve patients' received a copy of their written care plan as part of the Care Programme Approach (CPA). Staff had not documented whether patients had received a copy of their written care plan in three records. The multi-disciplinary team (MDT) introduced a ward round book. This encouraged patients to write down what they wanted to discuss but did not feel confident to say in person.

Families and carers attended formulation meetings and staff kept them updated on progress and developments.

A 'you say, we do' group was held once a week. The patients planned what they would like to do later in the week. The group met during our visit and planned to bake pizza and cookies two days later. We saw staff accompanied some patients on a shopping trip the following day to purchase ingredients for the activity.

The service manager told us they had previously involved patients in interviewing for new staff.

Staff encouraged patients to give them feedback through the 'young peoples' survey, which took place every three months. The service used this information to prepare a report and action plan. The action plan did not give any end dates so actions rolled over to the next survey. This meant we did not have assurance that the service had completed any of these actions.

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

Good

Access and discharge

Admittance was for patients in crisis either within or outside the catchment area. The service had a clear admissions policy and did not accept patients that required seclusion, demonstrated extremely aggressive behaviours and/or eating disorders. They would take into account the current mix and presentation of the existing patients. At the time of the inspection, there were 12 patients admitted to the service. Two patients were detained under Section 3 of the Mental Health Act and two were on leave. The average length of stay was 12 weeks.

The Willows stated that average bed occupancy was 91% over the last six months. NHS England funded these beds. The service reserved two beds for patients living in the catchment area. Patients always had a bed available to them returning from leave. Staff did not discharge patients after 1700hrs.

Staff liaised with home teams responsible for patients' wellbeing and local teams that struggled to attend inter agency meetings, offering flexible arrangements such as teleconferencing and off site visits. This did not affect the patients' care but could impact on the management of discharges. There were two delayed discharges up to 1 January 2016. These were due to placement delays.

Good

Child and adolescent mental health wards

The facilities promote recovery, comfort, dignity and confidentiality

The unit had a variety of rooms and equipment that met the patients' needs. The hospital had a clinic room, activity and therapy rooms, a sensory room and a day room containing a TV, multiple games consoles, CD's, books and board games. Staff utilised these rooms and equipment to optimise patients' treatment, care and recovery. For example, during the inspection, staff and four patients participated in a 'messy' play session involving sensory work and touching objects.

Patients did not have access to their mobile phones on site. Instead, a telephone was available to make private calls. Patients used a designated visitor's room to meet their friends and family. Visitors could only access the main ward or patients' bedrooms if agreed beforehand with the nurse in charge.

Staff supervised patient's access to their bedroom. For example, only patients feeling unwell could enter their bedroom during the daytime. This enabled the service to aid recovery by establishing a routine. We saw several patients had personalised their bedrooms, including their bedroom door. In addition, they had a lockable cabinet for secure storage of their possessions. Patients had supervised access to outside space.

Staff devised a structured, weekly activity plan, offering a range of therapeutic pursuits for patients. The service had developed links with local animal centres, who visited the service once a week bringing stick insects, snakes, and rabbits for the patients to care for. An art therapy group provided by an external organisation visited once a fortnight. This gave patients the chance of working with clay, which demonstrated more in-depth creativity.

The occupational therapist (OT) prepared an activities plan for those patients not taking leave at the weekend. Support staff facilitated these activities, as the OT did not work weekends. Activities included baking or trips out, dependent on the health needs of the patient. We attended an activity-planning meeting with staff and five patients. This led to the planning of various activities for later in the week, for example, outdoor sports, smoothie making, shopping for ingredients and baking pizza or cookies.

The service employed a teacher, who facilitated 25 hours education on site each week during school term times. Not all patients were well enough to attend. One patient attended a nearby outreach school for some subjects. The service had established strong links with external schools to enhance the provision and standard of education. Occupational therapy assistants (OTA) liaised with school and parents, arranging for work to be sent through for patients.

The OTA facilitated the weekly community meeting for patients. Members of the multi-disciplinary team also attended to help build and enhance therapeutic relationships with the patients.

Meeting the needs of all people who use the service

There were access ramps and disability bathrooms for patients with mobility difficulties.

The service could access interpreters and/or signers for those with hearing difficulties when needed.

Patients had access to a faith room that contained a variety of religious texts. In addition, the service organised trips to places of worship when required and filled notice boards with leaflets displaying contact numbers for organisations that could provide spiritual support.

Chefs prepared meals that met the patients' specific dietary requirements, taking into account culture, individual preferences and food allergies. The information boards in the dining room contained lots of information about the week's menus, the ingredients used and food allergies.

Listening to and learning from concerns and complaints

There had been 34 complaints in the 12 months prior to the inspection. Themes identified from the complaints were mainly complaints by staff about other staff members or previous patients complaining about the quality of care. The manager dealt with complaints in line with the provider's policy and none of the complaints were upheld. Staff informed us patients knew how to complain and would use their weekly community meeting to raise informal complaints.

An information board in a communal area displayed the complaints procedure. Staff supported those patients who wanted to raise a formal complaint with the manager, assisting them with their letters. The provider had a set

structure for dealing with and investigating complaints in a given timeline. Staff received feedback and learning resulting from complaints during team meetings and one to one supervisions.

Are child and adolescent mental health wards well-led?

Good

Vision and values

The provider had a vision and values statement designed to empower patients, 'Everyone has a personal best'. All staff we spoke with knew and agreed with their organisation's values.

Staff knew the names of senior managers within the organisation and said they visited the service. The service managers felt well supported by the senior team.

Good governance

There was a structured governance system in place. We saw regular performance management and quality assurance audits took place. The provider held monthly operational management meetings. The minutes showed the organisation held an overview of the safety of the service, monitored key performance indicators and maintained an oversight of performance. The Willows was working to 24 key performance indicators (KPIs) set by the provider at corporate level. These included accountability for restraints (restraint refers to direct physical contact where the intervener's intention is to prevent, restrict, or subdue movement of the body, or part of the body of another person), staffing and recruitment levels, safe admission and discharge.

The service had supervision and appraisal systems in place to ensure the effective management of staff. Staff received supervision every four to six weeks. Team meetings took place monthly.

Staff were able to submit items to the provider's risk register through the service manager. The Willows did not currently have any items on the risk register.

Leadership, morale and staff engagement

We saw evidence of clear leadership at local level and the clinical lead and service manager were accessible to support and guide staff.

There were no cases of bullying and harassment of staff reported in the last 12 months. Staff knew how to use the whistle-blowing process if they needed and felt they could raise concerns without fear of victimisation.

Morale and job satisfaction were good and all of the staff we spoke with enjoyed their work and showed a high level of commitment to the patients they supported. However, staff reported that the work could be stressful at times depending on the complexity of the patients. A staff mentoring scheme was available to new staff to support them to become part of the team.

The service manager stated they had sufficient authority to carry out their role and felt well supported by senior managers within the organisation.

The provider had a duty of candour policy, which staff understood and demonstrated how to use it.

Staff were given the opportunity to give feedback on services and input into service development through the staff survey. They felt they could feed into service development at a local level through their line manager.

Commitment to quality improvement and innovation

The Willows were in the process of seeking accreditation in the child and adolescent mental health service (CAMHS) quality network inpatient (QNIC), which was a national quality improvement programme.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that they update their Mental Health Act policy in line with the revised code of practice.

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

- The provider should ensure that all staff are compliant with Mental Health At training and training on the revised code of practice.
- The provider should ensure that all staff are compliant with Mental Capacity Act training.
- The provider should ensure that areas for improvement identified in action plans arising from patient feedback are completed.
- Environmental ligature risk audits should be updated to include sliding bedroom windows.

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	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The provider had not updated the MHA policy to reflect the revised Code of Practice. This was a breach of regulation 17 (2) (a)