Huntercombe Hospital - Stafford

Quality Report

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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

Are services safe?	
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	

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 did not rate the service as this was a focused inspection of one hospital ward. We found that:

- Areas of the ward were not clean and we found potentially infectious material in an open bin. Staff used the seclusion room daily to nasogastric tube feed a patient but did not clean the area before or after use.
- Staff did not always complete person-centred care plans that took into account the particular needs and preferences of patients on the ward.
- Staff imposed blanket restrictions on all the patients on the ward without any clear reference to individual risk assessments to justify their use.
- There was a lack of suitably qualified staff to deliver psychological therapies to the patients on the ward. As a result the ward did not provide the full range of psychological therapies recommended by the National Institute for Health and Care Excellence, and embedded in their model of care for the unit.
- Staff did not always update risk assessments after incidents and clinical discussions.
- The hospital relied on block-booked agency nurses to fill the majority of qualified staff roles on the ward.

However:

- The provider had improved the ward environment and had removed environmental risks, found on our last visit, to benefit the safety and dignity of patients.
- Staff had a good knowledge of safeguarding and reported concerns appropriately and in a timely manner.
- The provider's new local policy for rapid tranquillisation was in line with national guidance and specific to the treatment of patients.
- Staff followed the Mental Health Act Code of Practice guidance in their monitoring of practices such as restraint. They offered support to patients after an incident.
- Staff included patients in discussions about their care at regular multidisciplinary team meetings.
- Staff considered the principles of the Mental Capacity Act and Gillick competency when they assessed a patient's capacity to give consent.
- The hospital had a permanent management team that gave a period of consistency and stability in leadership.

Managers and the clinical team listened to the concerns of patients on the ward and acted promptly to investigate any concerns or allegations of abuse.

Summary of findings

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Summary of this inspection

Background to Huntercombe Hospital - Stafford

Huntercombe Hospital - Stafford is provided by The Huntercombe Group. Huntercombe Hospital – Stafford is a child and adolescent mental health service (CAMHS) for up to 39 young men and women, aged 8 to18 years. The hospital admits patients who are detained under the Mental Health Act.

The hospital has three separate wards: Hartley, Thorneycroft and Wedgewood wards.

- Hartley ward is a locked psychiatric intensive care unit (PICU) that provides 12 beds for male and female patients. The PICU offers inpatient care to patients suffering from mental health problems who require specialist and intensive treatment to address their needs. The service is led by a consultant child and adolescent psychiatrist and supported by a team of nurses, therapy and support staff. All patients on the PICU were detained under the Mental Health Act (1983). The provider had closed the unit following concerns raised about patient safety by CQC in our comprehensive inspection in May 2016. The PICU re-opened in April 2017. This inspection was focused on this ward.
- Thorneycroft ward is a general CAMHS acute assessment unit with 12 beds for patients aged 12-18 years. The patients treated in this unit have a range of diagnoses from psychosis and bipolar disorder to depression and deliberate self-harm. A consultant child and adolescent psychiatrist leads the team. Thorneycroft ward was last inspected in January 2017 and our findings can be found in the published report.
- Wedgewood ward has 12 beds and provides a specialist eating disorders service.

The patients treated on the eating disorders unit have a diagnosis of anorexia nervosa, bulimia nervosa, or other similar eating disorders. A consultant child and adolescent psychiatrist leads the team. Wedgewood ward was last inspected in January 2017 and our findings can be found in the published report.

A school on the hospital site provided education for the patients in the hospital. The Office for Standards in Education (OFSTED) regulates the school. They last inspected the school in March 2016 and rated it as good.

Huntercombe Hospital - Stafford is registered to carry out the following regulated activities:

- Accommodation for persons who require nursing or personal care
- Treatment of disease, disorder or injury
- Assessment or medical treatment for persons detained under the 1983 Act
- Diagnostic and screening procedures.

The hospital did not have a manager registered with the CQC at the time of this inspection. A new hospital director had taken up post on 1 March 2017, he successfully registered as the manager for this hospital in September 2017.

CQC last carried out a comprehensive inspection of the site in May 2016 and rated the service inadequate overall. CQC placed the hospital in special measures in August 2016. The organisation took a decision to close the PICU after this inspection and the patients were moved to alternative services by June 2016.

Following our inspection, the CQC, NHS England and The Huntercombe Group maintained a schedule of weekly, then monthly, engagement meetings. Senior management staff from the organisation, CQC inspectors and commissioners attended these meetings. The CQC monitored ongoing risks and improvements made to the whole service.

We re-inspected Thorneycroft and Wedgwood wards in January 2017. We found that the provider has made improvements to the quality and safety of the care provided on these wards. Following this inspection, we rated caring as **good** and we rated safe, effective, responsive and well led as **requires improvement**. This gave an overall rating of requires improvement. The provider had addressed the majority of issues that had caused us to rate the service as inadequate overall at the May 2016 inspection. At this point, the CQC took Huntercombe Hospital - Stafford out of special measures. However, there were some ongoing concerns. We told the hospital to take the following actions:

Summary of this inspection

- The provider must ensure that they remove blanket restrictions and that any restrictions are based on individual risk assessments of patients.
- The provider must ensure that policies and training on rapid tranquillisation are in line with up-to-date National Institute for Health and Care Excellence guidance**.**
- The provider must provide sufficient, appropriate and co-ordinated therapeutic activities, and access to psychological therapies must be available on all wards.
- The provider must introduce a management structure that encompasses therapy staff, and provide ongoing support through supervision and appraisal.
- The provider must ensure that all eligible clinical staff are trained in the Mental Health Act and the revised Code of Practice.
- The provider must ensure that all assessments of mental capacity are completed, and refer to both diagnostic and functional tests, and that a patient's right to refuse treatment is included in the description of the Gillick competency.
- The provider must introduce an audit of their compliance with the Mental Capacity Act and the application of the Gillick competency.

Our inspection team

Team Leader: Michael Fenwick, Inspector, Care Quality Commission

The team that inspected the service comprised three CQC inspectors and two specialist advisors (a consultant psychiatrist and a social worker) with experience in child and adolescent mental health services (CAMHS).

Why we carried out this inspection

We undertook this unannounced, focused inspection to find out whether Hartley ward had made improvements since it re-opened in April 2017.

The provider closed Hartley ward at the end of May 2016. Managers gave us notice of their plan to re-open the ward at the end of February 2017. Following further review of the plan with NHS England commissioners, the ward re-opened to patients at the beginning of April 2017. NHS England and the provider had agreed to limit admissions initially to two patients a week. By the time of our inspection, the provider had fully re-opened the ward and it was operating at full capacity.

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, asked a range of other organisations for information and sought feedback from patients.

During the inspection visit, the inspection team:

- visited Hartley ward at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with three patients who were using the service
- spoke with three carers of patients at the hospital

Summary of this inspection

- spoke with the ward manager, two block-booked agency staff nurses, two healthcare support workers, one psychology assistant and the medical team on the ward
- spoke with an occupational therapist, a deputy quality governance manager and a member of the hospital social work team
- received feedback about the service from NHS England and local authority safeguarding team
- attended and observed one handover meeting and a senior management team morning meeting
- looked at care and treatment records of six patients
- carried out a specific check of the medication management on the ward and looked at eight treatment cards
- looked at a range of policies, procedures and other documents that related to the running of the service.

What people who use the service say

We spoke with three patients on the ward. Common themes were the use of restraint, access to phones and the lack of therapy and activities.

All three patients had been subject to restraint and felt that staff were not always justified in using force and could try other strategies first. However, they also felt that staff were too slow in stopping aggression from other patients that threatened them. One patient had made a complaint about staff allegedly assaulting them. The provider had suspended the staff member immediately on receipt of the complaint, which was under investigation.

The only phone available for patients to use was a cordless handset that staff kept in the main office. Patients said that there was high demand for the phone and only limited access. This was a frustration when patients wanted to contact their relatives for additional support or confirm visits. Managers had told patients that they planned to issue simple mobile phones to all patients on the ward but there no fixed start date agreed.

The lack of psychological therapy and activities on the ward was the final common concern. The patients told us that activities were often repetitive and not very engaging. They preferred trips out and time away from the ward.

One patient told us that it was difficult to get support from staff if they were not on one-to-one observation. They reported waiting 15 to 20 minutes for a drink. Another patient expressed concern about the cleanliness on the ward and would have liked the opportunity to clean their own room. The patient used only using disposable cups as they were concerned about the cleanliness of the kitchen.

All patients felt positive about the time medical staff gave them. Patients felt involved in discussions at their multidisciplinary team meetings. Patients described the majority of staff as caring. One patient gave an example of a staff member who stayed with them to finish a conversation after the end of their allotted period of observation. The patient felt this allowed them to express their feelings fully.

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?

We did not rate the service as this was a focused inspection of one ward. We found that:

- Staff used one-to-one observations to engage with patients on the ward. Staff had relaxed restricted practices compared to previous practice on the ward.
- Staff had a good knowledge of safeguarding and reported concerns appropriately and in a timely manner. The hospital social work team responded promptly to any current or historic concerns raised by patients on the ward.
- The provider had improved the ward environment. Patients used the communal areas more frequently for activities.
- Prescription charts were in good order and had the appropriate treatment certificates attached.
- As the majority of patients were female, staff used bedrooms on the male corridor to accommodate female patients. Staff managed this gender mix effectively and in line with national guidance.
- Records showed that incidences of seclusion had ended within hours of starting. Staff complied with the relevant safeguards required by the Mental Health Act Code of Practice.
- The new local policy for rapid tranquillisation was in line with national guidance and specific to the treatment of children and young people. Staff attempted to monitor patients' physical health observations following an episode of rapid tranquillisation.

However:

- Patients reported that staff did not always respond promptly to incidents of self-harm. Staff reported that they did not always respond promptly due to the lack of available staff.
- The ward environment was dirty and we found potential infection risks in one bathroom. Staff used the seclusion room for a patient's daily nasogastric tube feed but did not clean the area after use.
- Most patients did not have positive behavioural support plans with options for de-escalation and distraction.
- Staff did not always update risk assessments after incidents and clinical discussions.
- The ward had high vacancy levels for qualified staff, which meant that the provider relied on block-booked agency nurses to fill the majority of shifts.

Summary of this inspection

Are services effective?

We did not rate the service as this was a focused inspection of one ward. We found that:

- Staff completed comprehensive assessments of patients on admission.
- Patients received physical health assessments and monitoring of any physical health problems.
- The clinical team received a three-week programme of induction and mandatory training before the ward reopened. The provider introduced staff to the new model of care proposed for the unit.
- The multidisciplinary team met daily to handover information about patients and incidents.
- Managers had created a supervision structure to support occupational therapy and social work staff. All staff received regular supervision.
- The provider employed a full time Mental Health Act administrator based at the hospital who oversaw all Mental Health Act related matters.
- Staff informed patients detained under the Mental Health Act of their rights on a monthly basis.
- Staff knew the difference between Gillick competence (applies to children under 16 years old) and mental capacity (applies to people 16 years and over).

However:

- Staff did not always keep care plans updated. Some care plans lacked clear goals and evidence of patient involvement.
- Patients did not have access to psychological therapies because of unfilled vacancies.

Are services caring?

We did not rate the service as this was a focused inspection of one ward. We found that:

- Staff were kind and caring in their interactions with the patients. They responded promptly to a patient's request for support.
- Staff had a good understanding of the individual needs of the patients they cared for, which staff and patients felt improved the quality of care.
- Patients received an induction to the ward on admission. They met the clinical team and received information on ward routines.

Summary of this inspection

- Staff involved patients in planning their care and offered them copies of their care plans. Patients attended their multidisciplinary team reviews.
- Staff encouraged patients to attend and lead weekly community meetings.

However:

- Some patients described some staff as abrupt and dismissive of their concerns.
- Some carers expressed concern about the quality of care and safety on the ward. Carers struggled to make contact with the ward by phone.

Are services responsive?

We did not rate the service as this was a focused inspection of one ward. We found that:

- Staff undertook advanced discharge planning in discussion with the patient and their family, and identified the aftercare arrangements for the patient's ongoing mental health and social care needs.
- Patients personalised their rooms with pictures and personal items.
- Staff allocated an extra bedroom as a lounge/activity area to a patient to meet his specific needs.
- Staff used the seclusion room to support the privacy and dignity of a patient who needed a nasogastric feed.
- The hospital had information in English readily available, and staff sourced information in other languages, when required.

However:

- The ward had limited space for therapies and activities.
- Patients said there was a lack of variety in the food they received, which was made worse by the two-weekly menu rotation.
- Patients had limited access to drinks on Hartley ward that was not justified by patients' individual needs and risks.

Are services well-led?

We did not rate the service as this was a focused inspection of one ward. We found that:

- Managers had developed a model of care specifically for the psychiatric intensive care unit that reflected the organisation's values and objectives.

Summary of this inspection

- Staff viewed the new ward manager positively. Staff felt they worked well as a team and offered one another mutual support.
- The provider block-booked agency staff, which helped create a cohesive team.

However:

- Staff felt under pressure to cope as the ward occupancy and acuity of patients increased.
- The hospital had problems with recruitment and retention. They had high staff vacancy levels, and relied heavily on agency staff.

Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings to help us reach an overall judgement about the provider.

A Mental Health Act reviewer last visited the ward on 22 May 2017. Managers had addressed the issues identified for action in a provider action report submitted to the CQC on the 12 July 2017.

All the patients on Hartley ward were subject to detentions under the Mental Health Act.

The provider employed a full time Mental Health Act administrator who was based at the hospital and oversaw all Mental Health Act related matters. The Mental Health Act administrator provided induction training to new staff on their role and responsibilities related to the Act. The Mental Health Act co-ordinator completed regular audits on Mental Health Act documentation, and these were reviewed at the monthly integrated governance meetings.

Staff discussed leave at each patient's multidisciplinary meeting and granted access based on an assessment of risk. Staff recorded any specific conditions made and shared them with the patients and their carers. On return from leave, staff recorded how the patient's leave had gone.

Mental Health Act documentation was easy to locate, in good order and included Approved Mental Health Professional (AMHP) reports. Patients had the appropriate treatments certificates that staff attached to their medication charts.

Staff informed patients detained under the Mental Health Act of their rights on a monthly basis. Patients had access to advocacy services. Where issues related to detention, staff made referrals to an independent mental health advocate service.

Mental Capacity Act and Deprivation of Liberty Safeguards

At the time of our inspection, 85% of staff were up-to-date with training on the Mental Capacity Act.

The provider had a policy that set out the key requirement s of the Mental Capacity Act and included the provisions of the Deprivation of Liberty Safeguards (DoLS). The hospital completed monthly audits on the use of the Mental Capacity Act and consent.

Staff understood the principles of the Mental Capacity Act and supported patients to make their own decisions. Staff knew the difference between Gillick competence (for children under 16 years old) and mental capacity (for people 16 years and over). Staff had a good understanding of the Mental Capacity Act's definition of restraint.

Child and adolescent mental health wards

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are child and adolescent mental health wards safe?

Safe and clean environment

- Hartley ward occupies the ground floor of the newer of two buildings on the hospital site. Dedicated reception staff controlled entry and exit to the building. They understood the security safety measures required and checked the identification of all external visitors. They issued keys and alarms only to approved staff and visitors.
- The layout of the ward allowed staff to observe all parts of the ward. Managers had completed an assessment of potential ligature points on Hartley ward. They had reduced some known risks during the refurbishment of the ward. They effectively mitigated continuing risks through observations and individual risk management plans.
- The layout of the bedrooms on Hartley ward meant that although there were separate washing facilities for the young men and women, the women had to pass the men's bedrooms to reach the toilets and showers. Staff asked young women to sleep in a bedroom on the male corridor when female beds were fully occupied. When this happened, staff increased observations of the corridor. At the time of our inspection, two female patients had bedrooms on the male corridor of Hartley ward. This was in line with their preferences as one patient identified as male (transgender), and the other wished to reduce her interactions and conflict with other female patients. Staff had ensured that one bathroom and toilet on that side of the ward was for their dedicated use. This meant they did not have to walk through communal areas and past male bedrooms to use female toilets and bathrooms.
- Emergency equipment was in good order, staff were aware of its location and we saw evidence of regular checks of the resuscitation equipment and drills to practice its use. In addition, the ward kept a ligature cutter as an additional piece of emergency equipment separate from the main bag. A ligature cutter is a hooked knife that allows staff to cut away any ligature tied close to the skin without harming the person. Staff had missed daily checks on its availability for use on 19 occasions since the beginning of May 2017 to the date of our inspection. The clinic rooms on the ward were clean and well equipped. Cleaning schedules and checks on the cleanliness of equipment were up-to-date.
- There was a seclusion room on Hartley ward. This included an observation room for staff. There was a camera in the room to reduce blind spots. The seclusion room met the requirements of the Mental Health Act Code of Practice 2015. Staff used the seclusion room to provide privacy to a patient they fed through a nasogastric tube while under restraint.
- We found that the communal areas and bathrooms on the ward were not clean. In one bathroom, we found a bin overflowing with rubbish that included soiled dressings. We discussed cleaning routines with domestic staff on both wards. They were aware of the risks associated with cleaning materials and locked things away when not in use. We did not see staff clean the seclusion room after its use for feeding a patient. We reviewed cleaning records and found they were up-to-date. We were assured that staff tried to ensure that the ward was cleaned regularly. The estates manager told us that cleaning staff had limited access to the ward on the day before our visit because of the high level of activity and risk. However, in most areas, furnishings were well maintained and the décor was intact. In some rooms, patients had applied graffiti to the walls, which staff planned to remove.
- Staff followed infection control procedures around maintaining good hand hygiene.

- The estates manager had completed and kept up-to-date a series of environmental risk assessments in areas such as water management and legionella testing.
- There was a nurse call system in the ward's communal areas and bedrooms. Staff carried personal alarms that they activated in urgent situations. The alarm system identified their location to other staff who attended to support them as soon as possible. The alarm sounded on the other two wards, which meant additional staff could attend in an emergency.

Safe staffing

- Hartley ward had a staffing establishment of 11 whole time equivalents (WTE) registered nurses and 26 WTE nursing assistants. There were seven vacancies for registered nurses. There were no vacancies for nursing assistants. The staff sickness rate was 0.74% in the three-month period from April to June 2017. Since the ward reopened, two staff nurses had left the service. Managers had filled their posts with a new starter and the transfer of an experienced nurse from Thorneycroft ward.
- Managers used a bespoke Huntercombe Group tool to estimate staffing levels. The tool relied on clinical judgement to estimate the number of staff required. The tool took into account the number of patients on the ward, their observation levels and their clinical need. We looked at staff rotas from when the ward re-opened to the end of June 2017. We found that staffing levels were maintained to the levels planned on all shifts.
- The ward manager block-booked full-time agency nurses. Managers included block booked agency staff in the extended induction and training weeks before they re-opened the ward. Managers and staff told us that agency staff were wholly integrated into the care team alongside permanent staff. Agency staff received a tour of the ward to familiarise them to its layout, the emergency response procedures, and the location of the resuscitation equipment.
- With at least two registered nurses on each shift, staff spent more time in the communal areas of the ward and ensured that patients received one-to-one time with their named nurse. Staff rarely cancelled leave because of too few staff.
- Managers ensured there were enough trained staff available on the ward at all times to carry out physical interventions. However, staff and patients described delayed responses at times because staff were busy. Staff from the other two wards at the hospital were available for support in addition to the staff on Hartley ward. Managers agreed to review response times to emergency calls when we raised this concern with them. There were no delayed responses reported in the incidents we reviewed.
- The provider had an on-call system for out-of-hours medical cover. Medical staff were available by phone and could attend the hospital in an emergency. The rota of on-call medical staff included consultant psychiatrists as well as GPs who were familiar with the hospital and patients. A consultant psychiatrist was always available by phone to assist in clinical decisions and the use of the Mental Health Act.
- All staff (including the block-booked agency staff) received a week of mandatory training as part of a three-week programme of induction and training before Hartley ward re-opened. Staff had received training in intermediate (100% of registered nurses) and basic life support (85% of nursing assistants). All staff were trained in the use of restraint and 62% in positive behavioural support.

Assessing and managing risk to patients and staff

- There had been three episodes of seclusion in the three months to 19 July, 2017. There were 256 episodes of restraint in the three months to the end of June 2017. On 54 occasions, staff used restraint to feed a patient using a nasogastric tube to maintain their physical wellbeing. The total also included 68 incidents where staff used cupped hand holds(a low level management approach) to manage a young person.There had been no reported prone restraints. Patients on the ward said that staff used restraint too frequently and with too much force. Managers were aware of these complaints and had investigated the most serious complaints with staff suspended during investigations. Managers had informed the police and the local authority designated officer who had called a strategy meeting to review the evidence. Staff provided support for patients following each episode of restraint. We saw staff had completed post-incident forms that comprised a brief description of the incident, a body map, details of any debrief or follow up they gave to the patient.
- We looked at the care and treatment records of six patients on Hartley ward. Staff undertook a risk

assessment of every patient on admission. We found that risk assessments were not always up up-to-date or comprehensive. Managers required staff to update this regularly and after every incident. In the four records we reviewed where there were multiple incidents reported, staff had only kept one fully up-to-date. However, staff had discussed the incidents in regular multidisciplinary team meetings, and the daily morning meeting of senior clinical staff who routinely reviewed incidents. Staff recorded these discussions in the meeting notes and shared them with the clinical team.

- We observed that staff on the wards had a good knowledge of the individual risks presented by the patients they looked after and the appropriate approach if they were distressed. However, we found only one detailed positive behavioural support plan that described the strategies for staff to use before using restraint.
- There were a number of blanket restrictions in place on the ward. Staff controlled access to phones, the internet, patients' bedrooms, the toilets at times, the outside space, and drinks. Patients had access to water at any time of day although they relied on staff to provide a cup. Hospital managers knew of the blanket restrictions on the ward and elsewhere in the hospital. They had reduced blanket restrictions on the other two wards and had a plan to reduce blanket restrictions on Hartley ward, in line with the previous requirement notice from the CQC.
- As all the patients were detained under the Mental Health Act, staff made sure they had information about leave arrangements, which required the consent of the responsible clinician.
- Staff used clinical observations as opportunities to engage with patients in activities and offer support. Staff conducted searches of young people's property on admission and after leave. Personal searches were conducted in line with a local policy and staff were required to seek the consent of a young person were possible.
- The provider had updated its local policy on rapid tranquillisation in line with the latest National Institute for Health and Care Excellence guidance (violence and aggression: short-term management in mental health, health and community settings) issued in April 2015. The new local guidance and training clearly directed staff to the dosages to be used differentiated by age and weight. The previous policy referenced out-of-date guidance and was not specific about the treatment of children and young people. The provider had complied with our requirement to update it.
- Staff completed post-incident records following any use of rapid tranquillisation. These included notes of any physical observations.
- Staff used seclusion appropriately. However, in the first case we examined during a Mental Health Act review visit in May 2017, we could not find evidence that staff offered a debrief to the patient who had been secluded. Otherwise, the documentation was in line with organisational policy and provided a clear and accurate record of each episode of seclusion. Managers reviewed episodes of seclusion in the senior management team meeting the next day to check the record keeping, to ensure debriefs had been held and to identify any learning that needed cascading to the team and organisation.
- At the time of our inspection, 99% of staff had received level three training in safeguarding adults and children. In addition, a group of medical staff, clinical leads and hospital managers had received level four training in safeguarding adults and children. This group of staff acted as safeguarding leads in the hospital supported by safeguarding champions on the wards. The lead social worker was responsible for the co-ordination of safeguarding within the hospital. The provider made safeguarding notifications and the hospital social work team had regular contact with the local authority designated officer for safeguarding children.
- Staff maintained good medication management practice with the support of an external pharmacist who visited the hospital weekly. The clinical pharmacist produced regular reports on compliance with regulations and any omissions or errors found in their scrutiny of prescriptions. The medication management committee reviewed these reports and implemented actions to maintain medicines safety.

Track record on safety

- Ward staff reported 22 serious incidents in the three months between April 2017 and end of June 2017. Incidents of deliberate self-harm and the use of restraint were the two main themes reflected in the serious

incident reports. All incidents were recorded at level three reflecting the need for treatment. There were no level one or two incidents reported more serious injury, harm or death
- Managers had reported all incidents that met the threshold for a statutory notification to the CQC in a timely manner. NHS England reported that they received prompt notifications of all incidents notifiable to them in line with their contracting agreements. The CQC had ongoing assurance and knowledge of lessons learnt and improvements made from regular monthly meetings with the provider and NHS England.
- Managers shared information about improvements with all staff through a simple summary report that staff discussed in supervision and at ward meetings. The provider had national corporate and local newsletters that focused on lessons learnt and reflected feedback from staff as part of its 'listening into action' project.

Reporting incidents and learning from when things go wrong

- All staff knew what required reporting as an incident and had access to the electronic incident reporting system.
- Managers had encouraged a culture of openness and transparency as part of the improvement programme after they went into special measures. Staff had a good understanding of the need to be open and transparent and explained to patients when things went wrong.
- The senior management team reviewed incident reports daily at a morning meeting and gave feedback to clinical staff on lessons learnt through the completion of a simple action plan. Managers shared lessons learnt within the hospital and across the Huntercombe Group.
- When managers identified changes from lessons learnt, they monitored the implementation of improvements and their effectiveness at their monthly governance meeting.
- There had only been one staff meeting on the ward since it reopened. The new ward manager told us that organising accessible monthly staff meetings was a priority going forward.
- Managers offered staff debriefs following significant incidents. A record was made of the debrief and managers reviewed the discussions to see if they could learn any lessons.

Are child and adolescent mental health wards effective?
(for example, treatment is effective)

Assessment of needs and planning of care

- We examined the care and treatment records of six patients on Hartley ward. All care records showed that staff completed an initial comprehensive assessment of the patient's needs within 72 hours of their admission to the hospital. Specific assessments from occupational therapy and education staff expanded on this initial assessment.
- Care records showed that patients received physical examinations and ongoing monitoring of any physical health problems.
- Four of the records we reviewed had care plans that were not up-to-date. They did not always show specific, measurable, achievable, realistic and time-limited (SMART) goals or reflect the preferences and views of the patients. In one case, the care plan contained a series of instructions for the patient without any evidence of collaborative working. However, staff kept detailed records of multidisciplinary team meetings that included the views of all the professional disciplines involved, the patient and their family.
- Staff stored care records securely on the provider's computerised care notes system. They also had summary information on paper for staff who lacked access to the electronic records and in case of system failure.

Best practice in treatment and care

- We found that prescribing followed National Institute for Health and Care Excellence (NICE) guidance and took into consideration cautions around prescribing medication for children and young people.
- The hospital did not offer patients the full range of psychological therapies recommended by National Institute for Health and Care Excellence because it had vacancies for psychologists. Hartley ward had limited input from assistant psychologists normally based on the other two wards. Managers tried to recruit to the vacant posts but staff retention remained an issue. Patients on the unit raised concerns about the lack of psychological therapy. However, an art therapist was in post and had started to work with individual patients.

- Medical staff on site supported physical healthcare needs and when a specialist opinion was required, they liaised with the local acute hospital or the patient's GP.
- Staff regularly assessed and continually monitored the nutrition and hydration needs of the patients. Following national guidance on the treatment of eating disorders, the hospital had support from a dietician, if required.
- Staff used recognised rating scales to assess and record severity and outcomes for the patients in their care, for example, the health of the nation outcome scales for children and adolescents (HoNOSCA).
- Medical staff and staff nurses were involved in an ongoing programme of clinical audits that included care and discharge plans, infection control, including mattress audits, and medication management.

Skilled staff to deliver care

- In addition to medical and nursing staff, the ward team had access to input from occupational therapists, assistant psychologists and family therapists.
- Managers had ensured 99% of nursing staff had received clinical supervision in the eight week period between 7 April and 31 May 2017 Local policy required that all staff receive supervision at least once every eight weeks. Since our visit to the hospital in January 2017, managers had also ensured occupational therapy staff received supervision on a regular basis.
- Managers had completed annual appraisals for all permanent staff within the year to the end of June 2017.
- All registered nursing staff were trained in naso-gastric tube feeding.
- Hospital managers had put in place an extended training and induction programme of three weeks for all ward staff prior to the reopening of the ward. The aim was to support a common understanding of the new model of care and to ensure clinical skills training was up-to-date and consistent across the staff group. It allowed staff to discuss approaches to care and work through some clinical scenarios to support team cohesion before any patients were admitted to the ward. Staff we interviewed were all positive about the impact of this training on their practice and it had improved confidence across the clinical team.
- Managers acted promptly to address any concerns about staff performance raised by patients and visiting professionals. Managers routinely monitored individual staff performance.

Multidisciplinary and inter-agency team work

- We observed a ward-based multidisciplinary team handover during our inspection. It included discussions of new incidents and any adjustments required to care. We also observed the daily senior management team meeting. The hospital director led these meetings to review activity at the hospital and any incidents from the day before. This was a multidisciplinary meeting with representatives from the three wards, the quality and data management team, and medical, social work, education and therapy staff. The meeting discussed potential safeguarding referrals and management plans to mitigate risks following any incidents.
- At the start of their shift, staff received a handover in the form of a written report prepared by staff on the shift before. These handover meetings discussed the allocation of duties for the shift ahead and advised of any specific issues or concerns.
- The hospital social work team and the ward staff had developed a working relationship with the local authority and the home authorities of patients from out of area. Staff had regular contact with the local authority designated officer for safeguarding children at interface meetings. Case managers from NHS England visited the hospital regularly. Staff kept them informed of clinical progress and incidents of concern on the ward.
- Managers organised an open day for external agencies when they reopened the ward. An executive member of the Huntercombe Group led the open day. The provider invited clinicians from the local CAMHS services, the local authority and NHS England to discuss the new model of care and look around the refurbished ward.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

- The ward admitted patients detained under the Mental Health Act.
- The responsible clinician checked the medical recommendations of detained patients on admission. They completed a form to evidence the completeness of the recommendations that supported the detention. For out-of-hours admissions, qualified nursing staff received and checked documents in the first instance and then passed them to the responsible clinician.
- The provider employed a full time Mental Health Act administrator based at the hospital. The role covered

receipt and administrative scrutiny of documents, checking the accuracy and completeness of leave authorisation forms, and uploading documents on to the electronic care records system. Administrators informed the Responsible Clinician of expiry dates of Mental Health Act sections and reminded nursing staff to inform patients of their rights.

- The Mental Health Act administrator arranged tribunals and hospital managers' panel hearings. Where a patient had not submitted an appeal, the Mental Health Act administrator had a system to remind them to send an automatic referral to the tribunal service. Staff on the wards knew how to contact the Mental Health Act administrator for help and advice.
- The consultant psychiatrist authorised patients' leave through a standardised system. Staff recorded any specific conditions and shared them with the patients and their carers. At each multidisciplinary meeting, staff discussed and granted leave based on an assessment of risk. Staff completed a specific form for patients who took external leave. They recorded a description of the patient, their destination and a risk assessment. On return from leave, staff recorded how the patient's leave had gone.
- The Mental Health Act administrator provided induction training to new staff on their role and responsibilities in relation to the Mental Health Act. All staff had completed training in the Mental Health Act within the last year before our inspection.
- Staff provided all treatment for detained patients under an appropriate legal authority. Staff kept statutory treatment forms known as T3 certificates with the medication cards.
- Staff informed patients detained under the Mental Health Act of their rights on a monthly basis. This included a verbal explanation and written information.
- We reviewed detention paperwork during our inspection. It was in good order and included approved mental health professional (AMHP) reports.
- The Mental Health Act co-ordinator completed regular audits on section 17 leave forms, section 132 (rights), capacity/competence forms, treatment forms and the use of independent mental health advocates. Managers reviewed these audits at monthly governance meetings.
- The wards had access to two advocacy services. One service provided advocacy support to all patients. Where issues related to detention, staff made referrals to an independent mental health advocacy service. Staff displayed posters for both services around the ward that included photos of the advocates. The multidisciplinary team would assessed whether the patient would benefit from the support of an advocate and made a referral accordingly.

Good practice in applying the Mental Capacity Act

- At the time of our inspection, 85% of staff had received training in the Mental Capacity Act.
- The provider had a policy that informed staff of the requirements of the Mental Capacity Act and included the provisions of the Deprivation of Liberty Safeguards (DoLS).
- Staff understood the principles of the Mental Capacity Act and supported patients to make their own decisions. Staff knew the difference between Gillick competence (applies to children under 16 years old) and mental capacity (applies to people 16 years and over). On admission, staff recorded the patient's capacity or competence to consent to admission. Where appropriate, staff asked patients' parents for consent on some issues.
- We found that staff had a good understanding of the Mental Capacity Act's definition of restraint. This included the use or threat of the use of force to make someone do something they are resisting, or restricting a person's freedom of movement, whether they are resisting or not.
- There was a regular monthly audit of the use of the Mental Capacity Act and consent at the hospital.

Are child and adolescent mental health wards caring?

Kindness, dignity, respect and support

- We observed caring and respectful staff interactions with patients on the ward. Staff attended to any distress exhibited by patients in their care apart from one occasion. Staff responded promptly to any patient's request for support.
- Three patients on the ward told us about their care. They described medical and occupational therapy staff as very caring, and said they listened to their concerns and involved them in care decisions. The patients were

Child and adolescent mental health wards

less positive about some nursing staff who they said could be abrupt and dismissive of their concerns. Two patients had made complaints and managers acted promptly to follow up their concerns.
- Staff had a good understanding of the individual needs of the patients they cared for. Both staff and patients felt that this personal knowledge improved the quality of care.

The involvement of people in the care they receive

- On admission, staff gave patients an induction to the ward and information on ward routines and the clinical team. The provider was developing an introductory pack for new service users and family members. This reflected the new model of care implemented on the ward.
- Staff involved patients in their care planning. Patients attended multidisciplinary team reviews to discuss their progress. Staff offered patients copies of their care plans but not all patients accepted them. However, in one case, staff did not fully support a patient's gender preference. We raised this concern with the medical director and managers as a potential breach of the regulation that required person-centred care, and non-compliance with the Equality Act 2010. However, staff allowed the patient to sleep on the side of the ward in line with their presference. The provider subsequently provided evidence that staff had talked to the young person again, and intended to refer to them in line with their established preference.
- Patients knew of the availability of advocacy services and were familiar with the local advocates who regularly visited the wards.
- Carers and community-based professionals told us that staff regularly invited them to care discussions. Carers expressed mixed views about the quality of care on the ward. Some praised exceptional care while others had concerns about the safety of patients on the ward. However, all carers we spoke with said they had difficulties in getting their phone calls to the wards answered.
- Patients had access to weekly community meetings where they could feedback any concerns about their care. Staff encouraged patients to lead these meetings and recorded any decisions as 'you said, we did' actions. Staff then displayed these actions on a noticeboard with an update on progress or completion.
- Managers routinely involved patients in the interview stage of staff recruitment.

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

Access and discharge

- NHS England commissioned inpatient CAMHS beds nationally. The West Midlands regional NHS England team worked closely with the hospital to secure a bed for a patient in their area, when required.
- Staff had not moved patients between wards since Hartley ward reopened for reasons other than clinical need. The model of care at the hospital supported such moves on clear clinical grounds and justified by a change in clinical presentation.
- Staff undertook advanced discharge planning in discussion with the patient and their family. Discharge took place during the morning to allow an early return home. Staff identified the aftercare arrangements for the patient's ongoing mental health and social care needs. In the case of patients previously detained under Section 3 of the Mental Health Act staff recorded aftercare arrangements in line with Section 117 of the Act.

The facilities promote recovery, comfort and dignity and confidentiality

- The ward had a clinic room but there was limited space where medical staff could examine patients. Physical examinations took place in the patient's bedroom to ensure privacy and dignity in the presence of a chaperone. The main communal area of the ward had a limited range of activities. The ward had designated rooms for education and activities but access was restricted. Therapy staff reported that there was limited space to hold one-to-one or group work sessions on the ward. Staff and patients had access to a larger meeting room on the first floor but this had limited privacy.
- Following the refurbishment of the ward, patients had access to light switches and nurse call alarms in their bedrooms. This improvement allowed the patients some control of their own environment.

- Staff had allocated a second bedroom as a lounge/ activity room to a patient to meet his specific needs for personal space away from other patients. In the second room, the patient had access to video games and other activities in a low stress environment.
- Managers had made available a room off the ward for visitors to young people on Hartley.
- Patients found it difficult to make private phone calls as they depended on staff for access to phones. Staff tried to accommodate private phone calls by allowing patients access to meeting rooms and other private spaces on the ward. Managers planned to allow the use of restricted mobile phones on the ward pending the outcome of the trial of this on the other wards in the hospital.
- Staff used the seclusion room as a safe and private place to administer a nasogastric feed to a patient. This planned intervention offered the patient privacy and reduced that chance of disturbance by other patients on the ward. We observed staff administering one feed. Staff ensured the privacy of the patient throughout the procedure.
- The ward had limited access to outside space because it was shared with another ward, and patients depended on staff to unlock the intervening doors between the wards.
- Patients on Hartley ward said the food tasted "ok" but they wanted more choices. One patient complained that the lack of variety was made worse by the two-weekly rotation of the menu.
- Patients had limited access to drinks on Hartley ward. This was not based on patients' individual needs or risks. Although water was available at all times, patients had to ask staff for a cup.
- Patients personalised their bedrooms with pictures and personal items. Staff securely stored personal items that were restricted because of identified risks. Patients asked staff for access to these items when they needed them.
- Hartley ward had activity workers who organised individual and group activities. We observed a planning meeting for activities over the summer holidays in the absence of school. Staff discussed each suggestion in detail and considered the potential individual risks of taking patients out of the hospital.

Meeting the needs of all people who use the service

- There were limited adjustments made to the ward environments to support people requiring disabled access. There was an accessible toilet located on the ground floor outside the entrance to Hartley ward. There were no disabled parking spaces to support disabled visitors' to access to the hospital.
- The hospital had information in English readily available. Staff sourced information in other languages, when required. Ward managers had provided patients with a wide range of information about local services, ward routines and their rights. Staff displayed some of this information on themed noticeboards on the wards and kept copies in leaflet form to give to patients. The ward noticeboard included daily updates on staffing levels and activities.
- Ward staff arranged for interpreters and/or signers to attend the hospital to support a patient's individual communications needs.
- There was a choice of food available to patients on the ward. Catering staff tried to accommodate personal choice, religious requirements or ethnic preferences. Staff completed regular audits of the quality of meals and service to gain feedback from staff and patients.
- There was no dedicated space for patients to worship within the hospital. However, patients had access to a meeting room outside the ward for prayer and reflection.

Listening to and learning from concerns and complaints

- The ward received eight complaints from the beginning of April to the end of June 2017. One complaint was upheld, no complaints were escalated to the Ombudsman.
- We saw information on complaints displayed in the patient areas. Patients knew how to make a complaint and two patients said they had complained about staff behaviour. Both patients had received acknowledgement of their complaints and had the opportunity to discuss their concerns with a manager.
- Staff understood the complaints management system. They tried to manage any complaints informally in the first instance.
- Staff received information on lessons learnt in an email-based bulletin.

Child and adolescent mental health wards

Are child and adolescent mental health wards well-led?

Vision and values

- Staff knew the provider's key values of individualised quality innovative care. Managers promoted the provider's aspiration of 'nurturing the world one person at a time' in information for staff and patients.
- Managers had developed a model of care specifically for the psychiatric intensive care unit that reflected the organisation's values and objectives.
- All staff knew of the senior management team who regularly visited the wards. Senior executives from the Huntercombe Group also visited the hospital regularly.

Good governance

- Before the ward reopened, the ward manager had reflected on past experiences and the concerns raised in previous CQC reports.
- Managers had effectively planned an induction period before the re-opening of the ward to ensure mandatory training and staffing levels would meet the expected demands of young people in acute distress. Hospital managers were actively recruiting to vacant registered nursing posts and the national leadership of the Huntercombe Group closely monitored vacancy rates.
- The Hartley ward manager discussed incident reports and audits at a monthly governance meeting with other ward managers and senior managers. These meetings involved a wide range of clinicians and senior clinical and administration managers. The hospital director shared decisions and lessons learnt with the national Huntercombe Group quality assurance team and regular specialist CAMHS service meetings.
- The new ward manager started in May 2017 and was setting priorities for developing the ward. He felt supported by the senior management team.
- The monthly governance meeting also managed the hospital's risk register. Staff informed managers of any risks. The managers took issues to their managers and the appropriate meetings for discussion and submission to the risk register.

Leadership, morale and staff engagement

- There were no bullying or harassment cases reported.
- Staff knew the whistle-blowing process and knew they could approach CQC with any concerns.
- Staff told us they felt positive when the ward reopened. They had received assurance from managers that staffing levels would meet the needs of patients. However, as occupancy grew and the complexity and challenges presented by the patients increased, they felt under pressure to cope. Managers and clinical leaders told us they were aware of these challenges and supported staff as the team settled into normal levels of activity. Staff viewed the new ward manager positively and said they had insight into the problems on the ward. The senior management team had stabilised since our visit in January 2017 with a permanent hospital director and quality governance managers in post. The nursing manager post for Thorneycroft and Hartley wards was vacant. The hospital director's preference was for a nurse director post with responsibility across the hospital.
- Staff felt they worked well as a team and offered one another mutual support.
- Qualified nursing staff had the opportunity to participate in a local university's leadership development course.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that they remove any blanket restrictions and that any ongoing restrictions are based on individualised risk assessments of patients.
- The provider must ensure that all areas of the ward are clean to reduce the risk of infection.
- The provider must ensure that there are sufficient, suitably qualified staff to deliver psychological therapies to the patients on the ward.
- The provider must ensure that treatment and care plans include the views and preferences of patients.

Action the provider SHOULD take to improve

- The provider should ensure that it takes into account the requirements in the Equality Act 2010 in planning care and treatment.

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 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **There was a lack of suitably qualified, competent, skilled and experienced persons to deliver psychological therapies to the patients on the ward.** **This was a breach of regulation 18(1).**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **We found that blanket restrictions were in place that were not necessary or proportionate as a response to the risk of harm posed to the service user or another individual. There was no evidence of any individual risk assessments to justify their application.** **This was a breach of regulation 13(4)(b).**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **Parts of the ward were dirty. There was no preparation or cleaning of the seclusion room to reduce infection risk when it was used daily to nasogastric feed a patient.** **This was a breach of regulation 15 (1)(a) and 15(2).**

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

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

Care plans did not reflect goals to achieve service users' preferences and ensuring their needs are met.

This was a **breach** of regulation 9(3)(b)