Watcombe Hall

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	Requires improvement
Are services safe?	Requires improvement
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 Watcombe Hall as requires improvement because:

- There were blanket restrictions in place that were not individually assessed. For example, bedrooms doors were kept open at night and wardrobe doors were kept locked regardless of risk of self harm. Parents could not visit children in their rooms and mobile phones were not permitted.
- Physical health observations, such as vital signs were not always followed up when patients had initially refused to have them taken.
- Staff were not familiar with the revised Mental Health Act Code of Practice and this was not included in the current Mental Health Act training, although action was being taken to rectify this.
- Although there were safe staffing levels and ward activities were rarely cancelled, patients told us that they frequently had to wait for care and support when staff were busy attending to other patients. There were gaps in specialist staffing, such as a social worker and family therapist. These roles had been recruited to and staff were due to start. The responsible clinician role was also vacant due to an internal promotion and this was covered by a locum consultant who was familiar with the service while recruitment took place.
- The service was full and there were three patients whose discharge had been delayed and length of stay was longer than clinically needed due to funding delays with ongoing placements. There were some delays with completing and some complaints within the agreed timescales.
- Staff were not up to date with completing annual appraisals, although an action plan was in place to fulfil this by the end of the appraisal year. Sickness rates were higher than average and the 2015 staff survey found that staff felt less involved in the overall vision and values of the organisation than the year before.

However:

- Patients and carers commented positively on the cleanliness. The service was clean and well maintained with up to date cleaning and environmental and maintenance records kept. There were good alarm systems in place to alert staff quickly if help was needed. There had been a number of recent improvements to the hospital, such as a new reception area, purpose built gym and occupational therapy kitchen.
- Staff were skilled and trained in de-escalation techniques and restraint was only used as a last resort.
- Staff reported high levels of job satisfaction, despite the pressures that they felt at times. They were supervised and trained and had access to developmental training, shadowing opportunities and reflective practice meetings.
- There was a range of multidisciplinary staff to provide specialist child and adolescent mental health (CAMHS) support and the service was continuing to actively recruit. There were therapies in place and a therapeutic timetable that patients followed. Young people were supported with individual programmes and were encouraged to attend college and use their local community. There was good interagency working and positive relationships with the local authority, GPs, safeguarding and other services. The provider had developed relationships with external agencies to improve community links and discharge planning. There was regular access to advocacy and patients were familiar with the advocate who visited the service each week.
- Staff were caring and respectful and this was supported by parents and carers who were very complimentary about the staff. Patients were complimentary about some staff but views from young people were mixed. Patients told us that the hospital was better than others then they had been to and some staff were singled out for praise. However, four patients complained about waiting for care when staff were busy attending to other patients and three patients told us that some staff did not always support them or understood their needs.
- Response to complaints showed that the hospital fulfilled its duty of candour because complaints were investigated and responded to and there were examples were lessons had been learned.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Child and adolescent mental health wards	Requires improvement 	

Summary of findings

Contents

Requires improvement

Watcombe Hall

Services we looked at
Child and adolescent mental health wards

Summary of this inspection

Background to Watcombe Hall

Watcombe Hall is an independent hospital that provides inpatient care for children and adolescents. There are ten specialist in-patient beds providing care and treatment for children and adolescents aged 13 - 18 years. There are two specialist units comprising of a four bedded female only psychiatric intensive care unit (PICU) and a six bedded mixed sex specialist adolescent unit. The unit was full, with ten female patients in residence at the time of our inspection.

The registered manager and accountable officer was in place. Patients could be admitted informally with parental consent, if under 16 years, or detained under the Mental Health Act.

The hospital is situated in Torquay in a semi-rural setting close to the beach. The service is close to a local GP and other services. There is an on-site school which supports young people with their education.

Watcombe Hall is commissioned by NHS England to provide specialist tier four CAMHS services. It assesses and treats children and adolescents with severe and complex mental disorders. The service is part of a specialist mental health services division (Huntercombe group) of Four Seasons health care.

We inspected the service in October 2015 and issued two requirement notices in relation to recording consent to treatment and patient record keeping. These were followed up as part of this comprehensive inspection and we found that both requirement notices had been met.

Our inspection team

The team that inspected the service comprised Sarah Lyle, team leader and one further CQC inspector, a Mental Health Act reviewer and a senior nurse specialist advisor.

Why we carried out this inspection

We inspected this service as part of our on-going 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 and during the inspection visit, the inspection team:

- visited the ward and the psychiatric intensive care unit (PICU), looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with two patients who were using the service and collected written feedback from patients;
- spoke with four parents of young people using the service;
- spoke with the registered manager and the unit manager for each of the wards;

Summary of this inspection

- spoke with 12 other staff members; including doctors, nurses, an occupational therapist, a psychologist and healthcare assistants;
- received feedback about the service from stakeholders;
- spoke with an independent advocate;
- attended and observed the weekly multi-disciplinary meetings;
- looked at seven care records and six treatment records of patients:
- carried out a specific check of the management of medication;
- reviewed five staff records, and;
- looked at a range of policies, procedures and other documents relating to the running of the service.

Information about Watcombe Hall

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

What people who use the service say

We received eight written comments from young people using the service. We also spoke to two patients during our inspection and spoke with four parents.

Overall, patient's comments were mixed. Some patients described the staff as very caring and supportive. One patient described the service as the best hospital they had been to. There were some negative comments including two patients who did not think that staff understood or supported their needs. We received four comments about waiting for staff to help while they were busy attending to other patients. One patient said waiting for care meant sometimes not getting their needs met when it mattered to them.

However, the most recent friends and family test results where patients comment on whether they would recommend the service, found that 16 out of 20 participants were likely or very likely to recommend Watcombe Hall to friends and family if they needed similar care or treatment.

Parents expressed high levels of satisfaction with the care provided. Parents were also complimentary about the staff. They told us that they were kept well informed about the care that their child was receiving and that issues and complaints were resolved in an open and transparent way. However, three out of the four carers despite feeling informed did not feel they were fully involved and included in the care and treatment.

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?

Requires improvement

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

- There were blanket restrictions that were not individually assessed. For example, locked wardrobe doors and bedroom doors kept open at night regardless of
- Two staff we spoke with were not clear about the processes for using the de-escalation room to ensure that it was always used for its purpose.
- There were recording problems with the e learning system which meant that some mandatory training was not being recorded.

However:

- The environment and equipment was clean and well maintained. Ligature risks were reduced as the environment was anti ligature and blind spots were mitigated by staff observation, mirrors and closed circuit television.
- Staff were trained and knew what to do regarding safeguarding children and adults. Staff were skilled and trained in de-escalation techniques.
- There was a full complement of nursing staff and the service continued to recruit in order to gain additional good quality staff.
- There were systems to manage and report risk and weekly multidisciplinary risk reviews for patients.

Are services effective?

Requires improvement

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

- Physical health observations, such as vital signs were not followed up when patients had initially refused.
- Staff were not trained in or familiar with the new MHA Code of practice.
- There were gaps in staffing which meant interventions, such as social work and some types of psychological therapy including systemic family therapy were not being provided, although family therapy and social work roles had been recruited to.
- Only five staff had received a recent appraisal, although there was an action plan in place to complete appraisals by the end of March.

Summary of this inspection

- There was no opportunity for individual clinical supervision for psychology.

However:

- There were skilled staff to deliver care and staff were offering therapies, such as dialectical behavioural therapy and cognitive behavioural therapy.
- Inter-agency links were well developed, such as transitional care for patients moving from child to adult services.
- Care plans were monitored and audited and consent to treatment was obtained and documented.
- Most staff were supervised. There were weekly reflective practice, shadowing opportunities and training sessions to enable staff to reflect on and refine their work.

Are services caring?

Good

We rated caring as **good** because:

- Most staff were caring and respectful and passionate about their work with young people.
- Patients were involved in their care planning and were given copies of their care plans.
- Parents and carers received regular contact from key workers and felt well informed with daily updates.
- Carers expressed high levels of satisfaction with the care and support that they and their family member received.
- There were opportunities for parents, carers and young people to be involved in the development of the service.

However:

- Three of the four parents that we spoke with did not feel fully included and involved in the care, including discharge planning for their child.
- Three young people reported that some staff did not understand their needs and patients and staff commented on delays when staff were busy attending to other patients.

Are services responsive?

Good

We rated responsive as **good** because:

- Beds were always available for patients on return from leave.
- The service brought young people who had been placed in other hospitals away from their home back to the area as beds became available.
- Children and young people could personalise their bedrooms.

Summary of this inspection

- There was a range of comfortable and well-kept facilities to promote patient recovery. An occupational therapy kitchen and fully equipped gym were waiting for final sign off and would enable children to learn how to cook for themselves and to keep fit.
- Patients knew how to comment and complain and had access to an independent mental health advocate.

However,

- Patients were staying longer than clinically needed with three people waiting for discharge due to funding delays.
- Some complaints' investigations were not completed in a timely way.

Are services well-led?

Good

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

- The management team had good oversight of performance through auditing and performance reporting systems.
- Risks were managed and monitored through a risk register.
- Staff felt supported by management to provide good opportunities for learning and development.
- Processes were in place to enable staff to whistleblow. Staff were confident in how to whistleblow if needed and felt confident to raise concerns.
- Sickness was monitored and staff were supported through occupational health where individual sickness rates was high.
- There were regular staff meetings where information was disseminated to the wider team.
- Staff were familiar with and had regular contact with the managers in the service and the wider organisation.

However,

- The 2015 staff survey found that staff felt less involved in the shared vision and values than in the 2014 survey.
- There were some morale issues amongst the nursing and care staff team attributed to staffing pressures and sickness rates were higher than average.
- Training records were not all accurate as there was under recording of some electronic learning records.

Detailed findings from this inspection

Mental Health Act responsibilities

Staff showed a good understanding of the Mental Health Act and there were regular audits to ensure that the MHA was being applied correctly. However, staff were not aware of or up to date with the Mental Health Act Code of Practice.

There were regular visits from an Independent Mental Health Advocate (IMHA) service that supported patients with their care and any meetings relating to their care.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff demonstrated a good understanding of the MCA and Gillick and Fraser competence in assessing capacity and were familiar with the principles of the Mental Capacity Act.

Records showed that consent was clearly recorded in care plans and was discussed in weekly multi-disciplinary meetings. There was evidence of patients being assessed for mental capacity as appropriate.

Overview of ratings

Our ratings for this location are:

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

Requires improvement

Child and adolescent mental health wards

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

Are child and adolescent mental health wards safe?

Requires improvement

Safe and clean environment

Watcombe Hall was clean and well maintained. There were up to date cleaning records in place, including completed weekly and daily check lists which demonstrated that the environment was regularly cleaned. Parents, carers and young people commented positively on the cleanliness of the buildings. Environmental risk assessments were undertaken regularly and there was a designated health and safety lead and who maintained this.

The ward layout allowed staff to observe in most areas of ward but there were some blind spots which were mitigated by staff observation, mirrors and closed circuit television. Nurses were present in each communal area at all times and positioned in observation points outside bedrooms at night.

A ligature point is a place to which someone intent on self-harm might tie something to strangle themselves. Ligature risks throughout the building had been mitigated through the installation of anti-ligature fittings, such as anti-ligature hinges on doors. Curtains and shower curtains were safe, although not anti-ligature by design.

The psychiatric intensive care unit (PICU) was for females only and the six bedded ward was mixed sex. At the time of our inspection the hospital was occupied only by female patients. The ward and sleeping area could be adapted to accommodate gender separation and complied with guidance on same-sex accommodation. All bedrooms had ensuite facilities.

There were fully equipped clinic rooms on both the PICU and the ward. The clinic rooms were well-fitted and clean. There was accessible resuscitation equipment suitable for children and young adults. Emergency drugs were checked on a weekly basis. Sharps bins were kept secure and correctly labelled. The medicine fridges were locked and the temperature was correct to keep the medicines safely. There was appropriate recording of daily fridge temperatures. All equipment, such as syringes was kept in correct storage and clearly labelled.

There was no seclusion room and patients were not secluded in any other area. However, the PICU had a de-escalation room and two staff we spoke with were not clear how to ensure that extra care provided in the de-escalation room did not result in de facto seclusion. De facto seclusion is when patients are not free to leave the area and associate with other patients. However, we did not see that there was any evidence of this occurring.

There was access to appropriate alarms and nurse call systems. Each staff member had a personal alarm and a back-up system of walkie-talkies connected to a pager system in the garden room where staff took their breaks.

Safe staffing

The provider had identified that there were 19% nursing and care staff vacancies in the twelve months up to December 2015. However, 12 care staff, including three staff nurses had recently transferred from a local Huntercombe group service that had closed and all care staff vacancies were now filled. There was a risk that staff would go back to

that unit once it reopened so the service was recruiting above its current staff establishment to ensure this did not have a detrimental effect. There was also a policy for over recruitment to attract good quality staff. A new staff nurse had recently been recruited and was due to start in March.

Sickness rates were above average with a 10% sickness rate for the year up to December 2015. Staff had been followed up with occupational health assessments where sickness was high or frequent.

Staffing levels were assessed using the Royal College of Psychiatry (RCPsych) quality network for inpatient child and adolescent unit staffing (QNIC) standards to ensure that the number of nursing staff on the unit were sufficient to safely meet the needs of the young people at all times. Staffing was also adapted to allow for changing needs of individual patients and agreed observation levels.

Staffing ratios were agreed as a minimum of four staff in the six bedded ward and four staff in the four bedded PICU during the day. At night there were three staff in each unit. This included two qualified nurses on each unit during the day and one qualified nurse on each unit at night. A twilight shift operated to provide more care to patients during the evenings. All staff worked across both units.

We reviewed a recent sample of the duty roster and saw that agreed safe staffing levels were maintained. There was appropriate use of bank and agency staff from an agreed list of staff that were familiar with the unit and had received the required mandatory and statutory training such as protecting rights in a caring environment (PRICE) training and behaviour support training.

We saw examples where staffing was adjusted and increased, when more staff were required for staff training, for example. However, three patients described the units as being short staffed, mainly where staff were focussed on attending to other patients, such as restraining a patient. Nursing and carer staff telling us they felt pressured at times reflected this view. Staffing concerns had been reported at the service clinical governance meeting where a lack of availability of agency staff familiar with the service meant that staff were asked to work additional shifts so there was a risk that staff would become tired and overworked. A recruitment campaign was ongoing to support the team by increasing staffing availability.

Staff and patients told us that escorted leave, such as walks and outings were regularly cancelled or delayed because staff were busy attending to other patients. We saw no examples of ward activities being cancelled because there were too few staff.

There were enough staff to ensure that patients could have regular one to one time with staff.

There was 24 hour medical cover in place. A part-time locum child and adolescent mental health services (CAMHS) consultant covering a vacant substantive post and a part-time permanent associate specialist doctor who provided medical cover during the day. The unit could also contact the group's senior medical consultant for advice and support and there was regular contact with the link GP practice. However, if psychiatric cover was needed out of hours then there could be a delay of up to one hour for medical staff to attend at nights and weekends as cover was provided from about 20 miles away. Both the unit manager and registered managers were on call out of hours.

The service was compliant with mandatory and statutory training. Training was delivered through a combination of face to face and electronic learning. Training rates were reported quarterly and the service met the agreed commitment with specialist commissioners between October and December 2015. However, there were recent problems with the electronic learning system which meant that there was under reporting of some staff training. This had been reported and work was underway to resolve this.

Assessing and managing risk to patients and staff

There was no seclusion room and no reported episodes of seclusion.

There were 235 reported episodes of restraint over the past 12 months. The restraints were concentrated on five patients on the PICU and nine patients within the main hall with two thirds of the restraints being for the five PICU patients. There were no reported prone restraints.

There were no negative comments in relation to restraint. One young person described feeling safe when they were restrained. One parent told us how well restraint is carried out holding people in a reassuring way that feels safe.

We reviewed seven care records. Individual risks were being regularly reviewed including during weekly multi-disciplinary team meetings.

Requires improvement

Child and adolescent mental health wards

Staff undertook a risk assessment of every patient on admission and updated this weekly and after every incident. A risk discussion took place for each patient in the weekly MDT and individual risk assessments for each patient formed part of the multi-disciplinary team checklist.

We saw an example where an incident was reported electronically and the risk assessment within the care record was updated accordingly.

Blanket restrictions which limit patients' choices should only be used if they are an unavoidable requirement in order to keep a ward safe. There were some blanket restrictions in place. Patients bedroom doors were kept open while they were in them, regardless of the patients' required observation levels and every patient's wardrobe doors were kept locked, even if they were not considered to be at risk of self harm.

We reviewed incident and care records and saw that restraint was only used after de-escalation had failed. All staff were trained in PRICE to use minimal restraint. Patients and parents were positive about the use of restraint to support patients.

There were no recent records of rapid tranquilisation.

The registered manager was the safeguarding lead within the organisation and was available for support and advice. All staff we spoke with were familiar with the safeguarding policy and knew how to make a safeguarding alert. Staff were clear on how to identify abuse and had received regular training updates. We saw that when concerns were raised by young people that these were acted on appropriately with the local authority.

Staff were trained in vulnerable adult and children's safeguarding and were meeting the commitment of 90% of eligible staff to receive specialist training. Between July and December 2015, 93% of eligible staff had completed safeguarding training.

We received information from stakeholders which confirmed that relationships with the local safeguarding team was good. The provider hosted the quarterly multi agency health safeguarding meetings at Watcombe Hall.

There was good medicines management practice. Medicines reconciliation was carried out with medical staff and GP on admission. Medicines were managed by a local pharmacy that carried out weekly checks. This included checks on the safe management of storage, dispensing and medicines reconciliation and advice to staff when needed.

Track record on safety

There were no serious Incidents in the previous 12 months requiring investigation with the NHS commissioning framework.

When there were adverse incidents the provider fulfilled their duty of candour by being open and transparent, informing people and providing support to those affected. We did not request to see any written evidence of duty of candour.

Incidents were logged and reported on electronically, staff were supported and care records were updated. The service highlighted that some low risk incidents had been flagged as not meeting the internal quality check of the investigation and review within the agreed timeframe. This had been flagged as a risk by the provider and an action plan was in place, however, this had not had an impact on patients.

Reporting incidents and learning from when things go wrong

All staff knew what to report and how to report incidents and they reported them on the electronic system. Staff received feedback from incidents. Incidents were discussed in the weekly multi-disciplinary team meeting, monthly staff meetings, supervision and weekly reflective practice.

Are child and adolescent mental health wards effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

We reviewed seven care records and saw that comprehensive and timely assessments were completed on admission.

We reviewed seven care records which showed that a physical examination had taken place Physical health checks were part of the multi-disciplinary team checklist in

the weekly ward round and physical health status was discussed each week and had improved since our last inspection. All physical examinations were arranged with the local GP and there was good liaison between the medical staff and the local GP surgery. The provider had undertaken a physical health care audit and reported quarterly to NHS England specialist commissioning team.

Care records showed evidence of up to date care planning and individual care including patient reviews. Care plans were recovery oriented, included strengths and goals. There was evidence that all patients had been given a copy of their care plan

Recording of information on the care records system had improved since our last inspection and information needed to deliver care was stored securely.

Best practice in treatment and care

We reviewed six medication charts and saw that medication was prescribed within British National Formulary limits for children and young adults. Best practice in prescribing and administering and monitoring medication, such as National Institute for Health and Care Excellence (NICE) guidance was followed. The medical team had provided recent face-to-face training updates on NICE guidance for prescribing medication. There was close liaison with a local pharmacist that provided weekly medication management. The pharmacist reviewed records to ensure that prescribing was within NICE guidelines.

Physical healthcare was primarily undertaken by the local GP practice and staff carried out some physical health observations for example, by completing vital signs. However, two care records showed that patients had declined physical health observations, such as blood pressure and pulse monitoring and one patient had no recorded observations since June 2015.

There were group therapies in place fitted around the school timetable. Therapies were provided as recommended by NICE, such as, cognitive behavioural therapy (CBT) and dialectical behavioural therapy (DBT). One patient was supported to continue to attend therapy in their local community. However, there was no current provision for systemic family therapy for the young people and their families or carers. The service was in the process of recruiting a family therapist who was due to start in May.

Staff used recognised specialist rating scales to assess and record treatment outcomes, such as, the health of the nation outcome scales for children and adolescents (HONOSca) and children's global assessment scale (CGAS). There was a commissioning requirement to demonstrate use of HoNOSca and CGAS to determine patients' health and social functioning. The psychologist also carried out other outcome ratings although this was not included in the multidisciplinary care notes.

Clinical staff actively participated in clinical audit and an annual audit cycle was in place with a calendar of scheduled audits, such as infection control, Mental Health Act and care planning. The lead nurse conducted monthly environmental and clinical checks.

Skilled staff to deliver care

The unit manager and associate specialist doctor were available for advice and the service could also contact the group's senior medical consultant for advice. The unit was seeking to appoint a permanent responsible clinician with a CAMHS background and this was covered by a specialist CAMHS locum consultant at the time of our inspection.

There were CAMHS specialist staff and other disciplines to support the specialist CAMHS service. However, there were some gaps in provision and the provider was actively recruiting to these. A CAMHS medical consultant post, family therapist and CAMHS social worker had all been recruited but were not yet in post.

The provider had appointed a regional CAMHS lead nurse to provide specialist nursing support and supervision to the registered manager and to lead on training for nursing staff. The first workshop had taken place and a series of training workshops for nursing staff were planned during the year.

Staff had received specialist training in CAMHS and this included shadowing staff at other provider services. More new staff had recently been introduced from a Huntercombe group service that had closed down and these staff were shadowing existing staff and receiving training as they were not CAMHS trained.

There was a range of supervision provided at Watcombe Hall. All the staff we spoke with felt supported and were enthusiastic about their roles. Supervision was provided through weekly reflective practice facilitated by specialist medical staff, one to one supervision meetings and regular staff meetings. The occupational therapist was supported

to be part of a new CAMHS peer support network for specialist occupational therapists in the Southwest but there was currently no similar network for specialist psychologists. The psychologist had received recent clinical supervision. Following staff changes, clinical supervision for psychology was due to be undertaken by the medical lead but this arrangement was not yet in place.

Appraisal rates were low and only five non-medical staff had received an appraisal in the last 12 months. The registered manager had informed NHS England specialist commissioners and was implementing an action plan to complete all baseline appraisals by the end of March.

Poor staff performance was addressed promptly and the unit manager gave examples of where disciplinary action and additional training had taken place.

Multi-disciplinary and inter-agency team work

We observed the weekly multi-disciplinary meeting and saw that this was conducted effectively. Individual risks were discussed and explored. Discussions showed the team were working collaboratively with the patients. Patients were supported by staff and the advocate was also present to support patients.

There was effective communication with a range of stakeholders. For example, the multi-disciplinary team worked closely with the transitional nurse who supported patients from child to adult services and the local authority designated officer.

All stakeholders we spoke with commented on the open and positive working relationships with Watcombe hall staff. External staff such as nurses and social workers attended meetings such as CPA and discharge meetings where parents and carers also were invited to attend.

Adherence to the MHA and the MHA Code of Practice

Staff had received training in the Mental Health Act (MHA) but were not familiar with the Mental Health Act Code of Practice. Although five copies of the Code of Practice had been provided, staff were unaware of them.

There was good evidence of an understanding of the MHA. Staff we spoke with all showed an understanding of the key aspects of the MHA which applied to their patient group. This was supported by what we saw in care records.

There was an underlying implicit understanding of the Code of Practice, for example, the hospital had a form for the statutory consultees to record their discussion with the SOAD and there was clear documentation to show this. However, we did not find evidence of staff being familiar with or making explicit use of the Code of Practice. We fed this back to the registered manager who was going to ensure that this was included in future MHA training.

There were regular audits to ensure that the MHA was being applied correctly and there was evidence of learning from these audits. For example, there was a very clear audit which showed that MHA activity was being carefully monitored by the administrator who picked up an error in the date of a medical recommendation and brought it to the attention of the MHA Section 12 doctor.

Young people had access to the Independent Mental Health Advocate (IMHA) service and knew who the advocate was. They had a weekly visit from the advocate who supported patients' with their care and attended multidisciplinary meetings.

Good practice in applying the MCA

Most staff were up to date with Mental Capacity Act (MCA) annual training with 65% of staff recorded as having undertaken the three yearly training in the last 12 months.

Staff were familiar with the five statutory principles of the Mental Capacity Act although two staff could not remember each statutory principle.

Staff we spoke with demonstrated a good understanding of Gillick and Fraser competence. Training in the MHA Code of Practice would reinforce the expectations for understanding the requirements for consent in children and young persons.

Records showed that consent was clearly recorded and in our observations of the weekly multi-disciplinary meeting.

Care plans showed evidence of informed consent e.g. patients were given information and there were discussions with patients about their treatment options. There was evidence of patients being assessed for mental capacity as appropriate.

Requires improvement

Child and adolescent mental health wards

Are child and adolescent mental health wards caring?

Good

Kindness, dignity, respect and support

We saw staff speak with people in a respectful way and witnessed empathy and warmth.

Staff engaged in activities with patients in one to one and small group activities. Staff were enthusiastic and spoke about their work with individuals in a very positive and respectful way. Carers we spoke with confirmed that staff were very supportive, considerate and respectful. During our inspection we saw staff provide both emotional and practical support.

Some patients told us staff were kind. However, overall patients gave mixed reports about how staff treated them. Some patients felt cared for and told us that staff were friendly. However, three patients felt that staff did not always treat patients in a supportive way that demonstrated staff had understood their needs.

Parents and carers told us that staff seemed genuinely pleased when their child progressed. We were told that staff had always showed understanding of their relative's individual needs. On the one occasion this had not happened it was quickly rectified and learning had taken place following a complaint.

The involvement of people in the care they receive

Staff maintained regular communication with parents and carers. Parents told us they felt informed about the care of their relative and confirmed that staff kept in touch with daily updates and progress reports. Despite regular contact some parents and families did not feel fully involved in the care and treatment plans, in particular the discharge planning of their relative. It was not clear from care records whether more family involvement in discharge planning had been considered.

Patients were actively involved and participated in care planning and risk assessments and this was evidenced in care plan records, one to one meetings and multi-disciplinary review meetings. Care plans were personalised and included patient's views in their own words. Patients were given a copy of their care plan and could choose which staff member to speak to for their one to one and key worker sessions.

A new admission pack and information brochure had been drafted by staff and was currently being reviewed by patients and carers. It provided young people and their families with information to about the service and what to expect. The draft admission pack contained information on the running of the ward, meal times, medication times, patient rights, advocacy contacts and the role of staff members in the multidisciplinary team.

Young people were able to give feedback and contribute to the development of the service. For example, fortnightly patient involvement meetings were held and there were monthly newsletters for patients and carers. Following a successful funding bid, recent improvements such as creating a new reception area and a mood room, which young people had named the chillax room.

The service had recently started monthly support sessions where parents' carers and family members were invited. These support sessions included learning and sharing support ideas. Parents confirmed they had been invited and received minutes when they could not attend. Most parents felt involved in the feedback and development of service.

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

Good

Access and discharge

Average bed occupancy over the six months between July and December 2015 was 98% for the acute ward and 99% for the psychiatric intensive care unit (PICU).

Multi-disciplinary staff reported that some patients were staying in the service longer than was clinically needed despite discharge planning.

Delayed discharges were reported monthly to NHS England. The provider had recently reported that there were three patients who were clinically well enough to

leave but the planned discharge had not happened yet due to delays in receiving funding for the placements, which was outside the provider's control. This included two patients on the PICU who no longer needed the level of care provided by the ward. One patient was due to transfer to a placement next week and leave arrangements were being implemented by the provider until the transfer took place.

The service was repatriating young people who had had to go to hospitals further away from home, back to the area whenever a bed was available and a waiting list system was in place. The provider was linking in with transitional care services and was currently working closely with the transitional care nurse to support patients moving from child to adult services.

The facilities promote recovery, comfort, dignity and confidentiality

The service had made recent improvements to the facilities for patients such as the Occupational Therapy kitchen and gymnasium. Staff had been trained to use the equipment and both rooms were awaiting final sign off at the time of our inspection and staff had been trained to supervise the use of the equipment.

Patients and carers were complimentary about the facilities. The reception area had been refurbished providing a welcoming space for families. Families could not visit the wards or individual bedrooms but there was a large multi-purpose meeting room which visitors could use. However, there was no designated private family room for visitors. There were plans to develop a family room. This had been identified as a need by young people and their families and commented on in previous surveys.

Young people could request to make phone calls to the advocate or a solicitor at any time and could make phone calls to family and other approved contacts outside of school hours and at weekends to encourage a school routine. No mobiles phones were allowed on the unit and patients and families were informed of this on admission. We did not see examples of individual risk assessments and alternative mobile phones offered, such as, mobile phones without camera access. However, as the location of the unit was not in a good mobile signal area, young people were provided with access to cordless phones which were available in the main hall and the PICU. Internet access was confined to the school room and was supervised.

The hospital was set in spacious grounds close to the beach. There was access to outside space and supervised access to the beach and the local area. However, three patients commented that supervised walks were frequently cancelled when staff were attending to other patients. Staff also described similar pressures on staff time.

The food was good quality with an emphasis on healthy eating. The 2015 patient's survey reported very high satisfaction rates both with choosing the menu options and the quality and quantity of the food. A request for improvements such as availability of fruit at all times had been granted and fruit was always available. However, there were differing views about healthier options. One young person commented that there was too much emphasis by staff on healthy choices and another thought that breakfast options needed to be healthier.

Young people could personalise their bedrooms. Pictures and posters and other personal items were in patients' rooms and in communal areas. There was young people's art work on display in communal areas.

A therapeutic timetable was in place for weekdays. There were structured psycho-educational activities for half a day followed by school in the PICU. In the main ward the timetable was reversed with school in the morning followed by therapy and activities in the afternoon. There were links with the local community and three young people were attending local colleges. On the first day of our inspection, young people went out to a climbing activity as part of their physical education lessons.

Most patients commented that there was not enough to do during the evenings and at weekends. This was also a finding of the 2015 patient survey where it was flagged that patients did not feel there was enough to do in the evenings and at weekends. The service was in the process of developing more leisure activities, such as the purpose built gymnasium.

Staff stored patients personal belongings in designated cupboards, belongings were inventoried on arrival at the hospital.

Meeting the needs of all people who use the service

The building was not purpose built and had few adaptations for disabled people. For example access to the

first floor bedrooms was by the stairs so the environment was restricted for wheelchair users. However it was possible to convert alternative ground floor rooms to accommodate patients with specific needs.

Staff pictures and names were displayed in the main reception area.

Information notices were on display which included details on the advocacy service. There was a patient involvement board with a patient survey action plan. Patient rights were displayed on the walls of the wards as were processes on how to complain.

There were links to local faith groups and churches. There was access to an interpreter, which needed to be arranged through the unit manager.

Listening to and learning from concerns and complaints

Watcombe hall received ten complaints in the 12 months previous to our inspection. Complaints had been investigated. Four of these had been upheld or partially upheld and a further four had been resolved at a local level. No complaints had been referred to the ombudsmen.

We reviewed three of the most recent complaints and saw that investigations were ongoing. Complaints responses showed that the hospital fulfilled its duty of candour. However, one complaint had not been completed in a timely way and had exceeded the time stated in the hospital policy to complete. The local policy stated that complaints should be investigated within 25 days.

Most patients and parents we spoke with or received information from knew how to complain and received feedback. All the parents we spoke with told us that their relative had been able to complain and that staff had acted quickly to resolve issues. For example, one complaint resulted in staff receiving additional training.

There was information on how to complain in the welcome pack for patients and carers. The advocate could support patients with complaints.

All staff we spoke with confirmed that patients were supported and encouraged to complain and comment. One parent told us that their relative was supported and felt able to complain freely and all parents told us that complaints were taken seriously and acted upon. Staff received feedback on the outcome of complaints at monthly staff meetings and weekly reflective practice meetings.

The 2015 patient experience survey found that all patients knew how to make a complaint. Staff we spoke with knew how to handle complaints appropriately and how to ensure the complaint was appropriately logged.

Are child and adolescent mental health wards well-led?

Good

Vision and values

Staff knew and understood the organisation's values at Watcombe Hall and of the Huntercombe group, the overall specialist provider. However, in the 2015 staff survey, staff reported feeling less engaged in the provider vision and values than the previous year.

Staff were aware that the organisation focused on valuing the individual and caring for patients in a safe therapeutic environment with a recovery focused model.

There was a unit manager and registered manager on site. Staff knew who the senior managers in the organisation were and confirmed that senior staff visited regularly. This included senior CAMHS support for medical and nursing staff.

Good governance

There were governance processes in place to monitor performance. This included clinical governance and senior management meetings, NHS England contract meetings and medicines management meetings. The provider had addressed requirement notices by CQC regarding a lack of documented risk assessment, lack of physical health care monitoring and lack of consent to treatment.

There was monthly monitoring of the risk register and assurance framework. Indicators of risk included incidents, physical interventions and medicines management. Processes to review risks took place and these were rated and reported according to severity and included actions to reduce identified risks.

Requires improvement

Child and adolescent mental health wards

Systems to monitor training and supervision were in place. However, issues with the electronic learning system meant that some records were not updated electronically when e learning had taken place. Managers were aware this under reporting and were awaiting the system repair. This was mitigated by recording manually and checking individual records.

Most staff had not received this year's annual appraisal. An action plan was in place to appraise all staff by the end of the March.

Shifts were monitored to check that there was sufficient numbers of staff of the right grades on duty and that there were sufficient administration staff to ensure that clinicians' time was spent on direct care activities.

There were systems in place to monitor incidents and safeguarding through clinical governance meetings and staff meetings. The clinical audit process was well managed with examples of changes made from audits such as care planning and Mental Health Act audits.

Systems were in place to respond to complaints and demonstrated that the hospital had fulfilled its duty of candour.

Leadership, morale and staff engagement

Staff were aware of the whistleblowing process and were confident about whistleblowing without fear of reprisal.

There was an internal whistleblowing line for the Huntercombe Group which meant that if staff did not feel confident approaching their manager then they were able to anonymously use that line.

Job satisfaction was high and staff were passionate about their work. However, some nursing and care staff morale was affected by stress which staff described as due to pressure on staffing, particularly when staff were off sick.

Staff sickness rates were higher than average and three staff reported that sickness had a negative effect on teams. Sickness was actively managed including referrals to occupational health to provide additional support and supervision.

The provider was aware of this and were actively recruiting. Regular staff meetings and supervision were in place to support staff. Staff told us that they felt supported by management.

Staff were enthusiastic about opportunities to develop professionally, for example leadership courses.

Commitment to quality improvement and innovation

There was a commitment to quality improvement and staff were enthusiastic to learn and develop as a CAMHS service. The service was a member of the Royal College of Psychiatrists accredited quality network for in patient CAMHS to demonstrate and improve the quality of inpatient child and adolescent psychiatric in-patient care through a system of self and peer review. Two staff had undergone peer review training in preparation for this.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must review the use of blanket restrictions across the service to ensure that restrictions are individually assessed.
- The provider must ensure that staff are trained in and familiar with the Mental Health Act Code of Practice so that this is reflected in their working practices.
- The provider must ensure that patients and carers have ready access to the Mental Health Act Code and to be purposeful the book should be on display.

Action the provider SHOULD take to improve

- The provider should ensure that staff and patients are supported when there are changes in levels of support needed by patients.
- The provider should ensure that staff are clear about the potential risk of de facto seclusion in the use of the de-escalation room in the PICU.
- The provider should ensure that all staff have access to appropriate and regular supervision.
- The provider should ensure that when patients decline to have their physical health observations such as vital signs measured, that this is followed up in a systematic way.
- The provider should ensure they are meeting their policy to fully respond to all complaints in a timely way.
- The provider should ensure there is an accurate record of staff electronic learning.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17(1)(2)(a) Assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. Providers must have regard to the Code of Practice and therefore it is necessary that their systems and processes reflect what they must have regard to. Staff were not aware of the Mental Health Act Code of Practice changes. Training in the Code of Practice had not taken place. This was a breach of Regulation 17 (1) (2) (a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9 (1) (a) (b) Service users must receive person centred-care. Providers must do everything reasonably practicable to make sure that people who use the service receive person centred care and treatment that is appropriate and meets their needs. There were blanket restrictive practices in place that were not individually assessed. This was a breach of Regulation 9 (1) (a) (b)