Good

Leeds and York Partnership NHS Foundation Trust

Child and adolescent mental health wards

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RGDY1	Mill Lodge	Mill lodge	YO32 9QA

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

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

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

Summary of findings

Ratings

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

Overall rating for the service	Good 
Are services safe?	**Requires improvement** 
Are services effective?	**Good** 
Are services caring?	**Good** 
Are services responsive?	**Good** 
Are services well-led?	**Good** 

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

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

- Staff carried out comprehensive assessments of a patient's needs on admission. This included risk assessments, which staff regularly updated. They treat patients with kindness, respect and compassion and engaged with them at an age appropriate level. Staff were knowledgeable about safeguarding patients from abuse.
- Patients and their relatives or carers were involved in the patient's care. Care plans were up to date, personalised and holistic. There was a full range of mental health disciplines providing input into a patient's care and treatment; this included structured therapeutic treatment and other activities to promote the patient's wellbeing. There was a full activities programme including weekends and evenings.
- There was an effective governance structure to monitor the unit's performance. Managers supported staff and provided appropriate training.
- Patients and relatives were able to give feedback on the service they received and input into the daily running of the unit.

However:

- Staff did not have a full understanding of what constituted seclusion and the procedures they needed to follow to ensure patients were protected by the safeguards of the Mental Health Act Code of Practice.
- Temperatures for the fridge used to store medications requiring refrigeration were sometimes outside the required range. It was unclear what actions staff had taken, if any, to ensure the medicines remained effective.
- Staff had not identified missed medication doses in their medication management processes.
- Patients did not like the food. There was limited choice for patients requiring food to meet their religious requirements.
- Staff did not update the information board for patients to see the staff members due on shift during a night time.
- The advocacy provided by the trust was not specifically for children and adolescents.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- Staff did not have a full understanding of what constituted seclusion. They did not implement the procedures they needed to follow to ensure patients were protected by the safeguards of the Mental Health Act Code of Practice.
- Staff did not update the information board for patients to see the staff members due on shift during a night time.
- There were full sharps bins in the clinic room requiring disposal.
- Temperatures for the fridge used to store medications requiring refrigeration were sometimes outside the required range. It was unclear what actions staff had taken, if any, to ensure the medicines remained effective.
- The unit had not archived or destroyed historical records relating to controlled drugs.
- Staff had not identified missed medication doses in their medication management processes.

However:

- The unit was clean and tidy with well-maintained furnishings.
- Risk assessments and management plans were of good quality and regularly reviewed.
- Staff were confident in managing aggression. They only used physical restraint as a last resort.
- Staff were knowledgeable about safeguarding patients from abuse. They had access to safeguarding leads for guidance and received safeguarding supervision.
- Staff knew what constituted an incident and how to report it. Managers were able to analyse and respond to trends.

Are services effective?

Good

We rated effective as good because:

- Staff carried out comprehensive assessments of the patient's needs in a timely manner.
- Care plans were up to date, personalised and holistic.
- Staff followed appropriate best practice guidance.
- There was a full range of mental health disciplines to provide input into the ward. They met regularly to discuss each patient with an holistic approach.
- Staff felt supported and received supervision and were supported by the trust to access specialist training for their role.
- Staff had a good understanding of the Mental Capacity Act and of Gillick competency.

Summary of findings

Are services caring?

Good

We rated caring as good because:

- Staff were kind, respectful and compassionate. They interacted and communicated in an age-appropriate way.
- Patients were involved in their care and able to give feedback on the service they received.
- Parents and carers were involved in the patient's care where this was appropriate.

However:

- The advocacy provided by the trust was not specifically for children and adolescents.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- Patients always had a bed to return to following any leave.
- The unit had a full range of rooms to support treatment.
- There was a weekly activities programme covering seven days and including evenings.
- The service was accessible to people with disabilities including wheelchair users.
- Staff knew how to handle complaints appropriately.

However:

- Patients did not like the food. There was limited choice for patients requiring food to meet their religious requirements.

Are services well-led?

Good

We rated well-led as good because:

- Staff were aware of the trust's values and knew who the senior managers were.
- Mill Lodge had an effective governance structure to monitor and assess its performance.
- Staff felt supported by their colleagues, the manager and the trust.
- Staff had opportunities to give feedback on the service or felt able to raise concerns without fear of victimisation.
- The staff reported that they were happy in their roles and worked together as one team.
- The ward was working towards the Royal College of Psychiatrists' accreditation for in-patient child and adolescent services.

Summary of findings

Information about the service

Leeds and York Partnership NHS Foundation Trust provide inpatient services for children and adolescents with mental health problems. The service is for both patients admitted informally and those detained under the Mental Health Act 1983.

There is one inpatient unit called Mill Lodge, located in Huntington, York. The ward can accommodate 16 young people of mixed gender, aged up to 18 years. It accepts referrals from across the UK.

The ward was previously based at Lime Trees in the Clifton area. In December 2015, it relocated into the refurbished premises at Mill View. The move enabled the service to increase the number of young people it could accommodate, from nine to 16. At the time of our inspection, there were 13 patients allocated to the ward; of these six were detained under the Mental Health Act.

The Care Quality Commission last inspected child and adolescent mental health services provided by the trust in October 2014 where it was rated as requiring improvement in the safe, effective, responsive and well led domains. Caring was rated as good. This resulted in an overall judgement of requires improvement. The concerns we identified on the visit have since been addressed.

Our inspection team

The team was led by:

Chair: Phil Confue, chief executive of Cornwall Partnership NHS Foundation Trust

Head of Hospital Inspection: Nicholas Smith, Head of Hospital Inspection (North West), Care Quality Commission

Team leaders: Kate Gorse-Brightmore, Inspection Manager, Care Quality Commission

Chris Watson, Inspection Manager, Care Quality Commission

The team that inspected child and adolescent mental health wards consisted of two CQC inspectors, one pharmacist and three child and adolescent mental health specialist advisors.

Why we carried out this inspection

We inspected this core service as part of our on going comprehensive mental health inspection programme.

How we carried out this inspection

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients at a focus group.

During the inspection visit, the inspection team:

Summary of findings

- visited the wards and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with eight patients who were using the service
- spoke with three carers of patients using the service
- spoke with the manager of the ward
- spoke with 21 other staff members; including consultants, doctors, nurses, teachers, administrators and other allied mental health professionals
- attended and observed hand-over meetings and multidisciplinary meetings
- observed patient activity groups
- collected feedback from patients using comment cards
- looked at six treatment records of patients
- looked at all medication records of patients
- carried out a specific check of the medication management
- looked at policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We spoke with eight patients using the service and three parents.

Patients told us they felt safe while on the unit and that it was friendly and welcoming. They mostly spoke positively about the staff, describing them as approachable and nice. Patients informed us that staff asked about their likes and dislikes and were involved in their care from the start of their admission. They liked their rooms and said the unit was always clean and tidy. Patients told us they could discuss things about their treatment and were involved in changes.

One patient told us staff were patronising. Another told us that they felt uncomfortable having staff they were not familiar with watching them sleep.

Parents felt there were many therapy options and staff were open with them when discussing their child. One parent felt staff did not listen to her concerns regarding her child's unescorted leave.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure staff have a full understanding of what constitutes seclusion and that they follow the follow the Mental Health Act code of practice when this occurs.

Action the provider SHOULD take to improve

- The trust should ensure that medications are stored within the required temperature range.
- The trust should ensure that the medicines audit procedures identify all missed signatures on the prescription charts.
- The trust should ensure the unit provide meals to meet a patient's dietary requirements taking into account cultural and individual preferences.
- The trust should ensure patients have access to advocacy specifically for young people.
- The trust should ensure that patients are informed of the staff members due on a night time shift.

Leeds and York Partnership NHS Foundation Trust

Child and adolescent mental health wards

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Mill Lodge	Mill Lodge

Mental Health Act responsibilities

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

The service had six patients detained under the Mental Health Act. Staff regularly explained to them their rights under section 132 of the Act. Patients were receiving treatment authorised by the appropriate certificate. We saw that copies of the certificates were stored with their prescription cards. In each case, staff recorded an assessment of capacity to consent to the treatment.

The service kept clear records relating to section 17 leave under the act; these included risk assessments.

Administrative support and legal advice on the implementation of the Mental Health Act and its code of practice were available from a central team. The team carried out checks to ensure the correct application of the act.

Staff supported patient to use the advocacy service and the trust's patient and liaison service visited weekly.

Mental Capacity Act and Deprivation of Liberty Safeguards

The Mental Capacity Act and its principles apply to those patients aged 16 and over who were treated informally rather than detained under the Mental Health Act 1983. For children under the age of 16, their decision-making ability is governed by Gillick competence. The concept of Gillick competence recognises that some children may have sufficient maturity to make some decisions for themselves.

Staff had received training in both the Mental Capacity Act and Gillick competency. They had a good understanding of both. They supported patients to make their own decisions where appropriate and they discussed capacity and consent as part of multidisciplinary meetings and handovers.

Requires improvement

Are services safe?

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

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

Our findings

Safe and clean environment

Mill Lodge was clean with well-maintained furnishings. Domestic staff maintained cleaning schedules, which were up to date, and demonstrated that staff had regularly cleaned the environment. Patient led assessments of the care environment (known as PLACE) had been undertaken in 2015 for Leeds and York Partnership NHS Foundation Trust in relation to cleanliness. Independent assessors rated Mill Lodge at 99% for cleanliness, which is above the England average of 98%.

The ward layout was similar to a figure of eight. Patients' bedrooms were located around one circular corridor. Offices, the dining area and lounge were around another circular corridor. Therefore, staff did not have clear lines of sight to both areas at the same time. This meant staff were often dispersed around the unit to ensure the safety of the patients. Staff carried personal alarms and knew how to respond when an alarm was activated.

The unit had completed a ligature audit that was in date. A ligature point is a place where a patient intent on self-harm might tie something to strangle themselves. Patients' bedrooms were ligature free. However, there were some ligature points in communal rooms. Staff managed these risks through individual risk assessments and observations where needed. The unit had three sets of ligature cutters located around the building in case of an emergency.

The unit had segregated male and female patients' bedrooms. There was an adaptable section between the male and female areas which could be used by either gender depending on the mix of patients at any given time. Each separate area had its own shower room and toilets. This allowed the unit to meet the Mental Health Act code of practice on same sex accommodation. None of the rooms had en suite facilities.

The clinic room was tidy and well maintained. Staff had access to emergency equipment and emergency drugs. Staff carried out nightly checks on all equipment; this included the oxygen cylinder, the emergency bag for resuscitation and batteries in monitoring equipment. The room contained clinical waste disposal bins for used sharps; there were four sharps bins that were full and should have been removed for disposal.

Staff recorded the temperature for the fridges used to store medications. They did this mostly on a daily basis. However, we saw gaps in the recording for four days in the previous month. There were also recordings of temperatures outside the required range and it was unclear what actions staff had taken to address this. This meant staff were unable to provide assurances that medicines requiring refrigeration were stored at the appropriate temperatures to remain effective.

Staff had started to record the temperature of the room used to store other medications not requiring refrigeration from 16 June 2016. We were therefore unable to verify whether medicines had been stored safely prior to this period.

The unit had a high dependency room. Some staff told us that the door to the room was never shut and that staff remained with the patient. However, the patient would be prevented from re-joining their peers if they were still distressed, even after any restraint had been released. This meant that patients were being deprived of their liberty and therefore these episodes met the Mental Health Act definition of seclusion. During our inspection, we spoke to staff of different levels. There was clear confusion among the staff as to the use of the high dependency unit and their recognition of when a patient was secluded.

The room had clear observation and a separate toilet and shower area. There were beanbags, a sofa, bed and television. There was no clock in the room as required by the Mental Health Code of Practice.

Staff adhered to infection control principles. There were anti-bacterial gels around the unit and appropriate signage for staff, patients and visitors.

Safe staffing

The trust had established staffing levels at Mill Lodge as 18.8 (whole time equivalent) qualified nurses and 13.8 (whole time equivalent) nursing assistants. The area manager specified the number of staff required on each shift. These were six staff on an early day shift, which

Requires improvement

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included three qualified nurses, the same on a late day shift and four staff which included two qualified nurse on a night shift. Ward managers were able to increase these levels based on the clinical presentation of patients.

At the time of our inspection, the unit had six qualified nurse vacancies. This was due to staff leaving mostly for career progression. There had been a delay in recruitment due to trust recruitment events taking place in Leeds; these did not attract staff wishing to work in York. The trust recognised this and carried out a further recruitment campaign specifically for York. The unit recruited to all six vacancies. The new staff were due in post by September 2016. There was one nursing assistant on long term sick.

During the period of low staffing, Mill Lodge aimed to fill shifts using both bank and agency workers. Managers were able to specify which staff they required; this supported consistency in the service and familiarity for patients. Data provided by the trust showed us that the unit had not managed to meet the required staffing levels for 82 shifts during 1 January 2016 to 30 June 2016. Bank and agency staff had been used for 423 shifts in the same period.

Shifts did not always consist of the expected number of qualified nurses but did mostly meet the number of staff required on the unit. We looked at recent staff rotas and noted there were at least two qualified staff on each shift. Staff told us they felt the staff levels were very good as the patient to staff ratio remained high. They did not compromise the patient's care and staff were mostly familiar with the unit. The service did not cancel activities or leave due to staff issues.

Patients told us they knew who their key worker was. They told us, and records confirmed, that they received regular keyworker sessions. However, they were not comfortable being observed on a night-time when they were unaware of which staff would be doing this. Managers had tried to rectify this using a board so patients could see which staff members were due on to the night shift. We looked at this board during the inspection and saw that staff had not completed it. Staff told us this was regularly left blank.

There were two consultants employed within Mill Lodge; this provided adequate medical cover day and night in an emergency.

Staff were required to complete mandatory training units. These included clinical risk, life support, physical interventions, information governance, safeguarding and the Mental Health Act. Staff had an overall compliance of 89%. The lowest compliance was moving and handling essentials, which was at 58%. This took place in Leeds making it difficult for staff to attend. We saw no impact of this on care.Staff were 100% compliant in moving and handling principles. All other training requirements were above 75% compliant.

Assessing and managing risk to patients and staff

Staff had all received training in managing violence and aggression; this included all members of the multidisciplinary team. They told us they were confident in managing aggression using the correct techniques. Staff only used physical restraint after other de-escalation approaches had failed, for example, distraction and talking. During the period from 1 January 2016 to 30 June 2016, the unit had used restraint on patients on 39 occasions. Four of these incidents had resulted in prone restraint. Staff followed the trust policy for guidance and monitoring on these occasions.

If restraint continued for a long period, we were told that staff moved patients to the high dependency unit where patients may be prevented from leaving the room. Staff were vague on what constituted seclusion and what procedures were required if seclusion was used. We asked the trust for the number of seclusion episodes from 1 Mar – 30 Jun 2016 and they informed us that there were 10 occasions when a patient was secluded. However, on inspection, some staff informed us that seclusion was never used. The manager informed us that they used some documentation from the trust seclusion policy but did not carry out medical reviews. On request, staff were unable to provide us with any clear seclusion records as specified in the trust policy. This meant that when restrictions placed on a patient amounted to seclusion, not all of the safeguards required by the Code of Practice and the trust policy were put in place.

Staff managed patient risks effectively. Risks were communicated to the service via the referrer prior to a patient's admission. Staff then conducted an additional assessment using a safety assessment and management plan tool. The tool prompted staff to explore risks including self-harm, suicide, violence and aggression, exploitation, self-neglect and harm to others. Staff rated risks on their current significance. From the assessment, staff completed a management plan detailing how the identified risks would be mitigated; this took into account the patient's

Requires improvement

Are services safe?

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strengths and protective factors. We looked at the records of six patients. All contained up to date risk assessments. Staff also discussed risks during handover meetings and multidisciplinary meetings.

The service had house rules and expectations designed to keep their patients safe and encourage recovery. Staff communicated these to patients prior to their arrival and on their admission. Patients had dedicated time in which they were able to access social media via the unit's computers; the unit did not allow mobile phones with internet connection or camera facilities. Patients had limited access to their bedrooms during the day; this was to prevent a patient becoming isolated and encouraging meaningful activities and establish a normal daytime routine. Staff individually assessed this with the patient and reflected this in care plans.

Staff followed policies for the use of and documentation of observation. The multidisciplinary team reviewed levels of observation on a daily basis. The unit had a list of restricted items that included alcohol, drugs, razors and weapons. The staff did not routinely carry out searches apart from on admission. Any additional searches were included in a patient's care plan on an individual basis. There was a trust policy that staff were aware of, and followed if they had reason to believe this was necessary.

Staff knew what constituted a safeguarding concern and how to report it. The trust had a central safeguarding team staff used for guidance and to liaise with local safeguarding authorities. Managers discussed safeguarding in team meetings and they discussed any concerns in handover meetings.

All qualified staff were required to undertake level three training in safeguarding for children. The unit was 94% compliant with this. Other staff were required to train up to a minimum of level 2; staff were 77% compliant, this was lower due to long-term sickness and maternity leave. Staff received safeguarding supervision on a monthly basis. Qualified staff led the sessions, which gave the opportunity for staff to seek support and advice due to the environment they worked in.

Medicines were securely stored in a locked cabinet in a locked clinic room. There were no controlled drugs being stored at the time of our inspection. There was an appropriate controlled drug cabinet available, which was compliant with legal requirements if needed. Records also confirmed that staff kept the appropriate records for the ordering and storage of controlled drugs previously used on the unit and that required audits occurred. However, these records dated back to patients in 1983 meaning the service had ineffective procedures in place for archiving and destroying historical documents.

Patients' medication cards were clear and legible. They contained photographs of the patients as a safeguard against incorrect dispensing. We looked at all the patients' medication cards. There were four missed doses of medication that staff had not identified in routine audits.

Track record on safety

Mill Lodge had no recorded serious incidents requiring investigation in the 12 months prior to our inspection.

Reporting incidents and learning from when things go wrong

Staff were able to describe and give examples of what constituted an incident and how to report it. The service used staff from other trust teams to conduct debriefs, offering support and reviewing what worked and they how they could have been managed the incident differently. Senior staff reviewed all incidents and feedback cascaded to staff through emails and handover meetings.

Managers were able to extract information through the incident reporting system in order to monitor trends. On review, they established that incidents occurred mostly during the evening. In response, the service increased planned activities in the evenings resulting in a reduction in incidents.

Are services effective?

Good

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

Our findings

Assessment of needs and planning of care

Following admission, staff completed a comprehensive and timely assessment of a patient's treatment needs. Assessment continued over a period of four to six weeks, during which time the staff aimed to establish a relationship with the patient and their parents or carer. We looked at six patients' records and found detailed assessments for each patient considering their mental health, physical health and their wider social needs.

All patients had a standard care plan within 72 hours of admission. Following this, relevant members from the multidisciplinary team contributed to a personalised care plans for each patient. All six patient's records we looked at had personalised and up to date care plans. The records were holistic and mostly recovery focussed. Two of the six records lacked detailed plans directing towards a patient's eventual recovery. All the care plans included therapy approaches, parent and carers plans and visiting arrangements.

Staff monitored a patient's physical health throughout their stay at Mill Lodge. This was evident in the care plans and formed part of regular multidisciplinary discussions.

Records were both in paper format and kept on the trust's electronic database. Paper files were stored securely in lockable filing cabinets. Agency staff did not have access to the electronic records and therefore used the paper files for information.

Best practice in treatment and care

The medical team prescribed medicines in accordance with the National Institute for Health and Care Excellence guidance. For example, the service followed guidelines on depression in children and young people, social anxiety disorders, phobias, obsessive-compulsive disorder, managing violence and aggression specific to child and mental health services and self-harm. Staff followed Junior Marsipan guidance to manage patients with anorexia nervosa. The Royal College of Psychiatrists recommend this guidance as best practice. The pharmacist reviewed all prescription charts to ensure the appropriate clinical interventions. Records clearly showed a patient's weight for staff consideration when prescribing. Staff had access to an up to date British National Formulary for children for reference. This is a pharmaceutical reference book that contains a wide spectrum of information and advice on prescribing and pharmacology.

Patients had access to appropriate psychological therapies. These included cognitive behavioural therapy and dialectical behaviour therapy; staff delivered these in individual and group sessions. The service offered family therapy to all patients and their families; approximately 90% of the families participated in this intervention.

Staff used a range of recognised rating scales to assess and record severity and outcomes. These included the health of the nation outcome scales for children and adolescents. This covered 12 key health and social areas and helped clinicians to see how the patients responded to interventions over time. They also used the children's global assessment scale to rate the patient's general functioning and the strengths and difficulties questionnaire for behavioural screening.

Staff participated in clinical audits to monitor the service's performance and make necessary changes. These included a weekly clinic check, care plan audits and an observation audit.

Skilled staff to deliver care

A full range of experienced and qualified mental health disciplines provided input to a patient's care and treatment. These included a consultant psychiatrist, two psychologists, occupational therapists, a dietician, a family therapist, activities co-ordinator, mental health nurses, teachers and support workers. At the time of our inspection, there was one social worker vacancy, which the trust was in the recruitment process. A trust pharmacist visited most weeks and there was daily communication with pharmacy support if this was needed. The unit also employed administrative and domestic support.

Staff felt supported and received regular supervision. They had separate clinical and managerial supervision. Staff were able to choose their own clinical supervisor to ensure an effective support system. They also participated in reflective practice supervision. Staff attended this in groups giving staff the opportunity to share concerns and seek peer support.

Staff received, and were mostly up to date with annual appraisals. This meant they had clear goals and objectives,

Are services effective?

Good

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

which their manager reviewed regularly. This allowed the manager to identify improvements and assess the quality of care staff provided. The unit was 84% compliant with annual appraisals.

The unit used handovers as an opportunity to share organisational information, lessons learnt and cascade any information from operational meetings. The manager used email to ensure all staff received updates.

Additional to mandatory training, the trust supported staff to participate in related specialist training. These included staff who had attended training in dialectical behaviour therapy and consent training specifically for children and adolescents. The trust supported occupational therapists to train in sensory integration therapy. This therapy enhances treatment for children and adolescents who may be under or over stimulated. The trust also provided the resources required to deliver this intervention.

Multi-disciplinary and inter-agency team work

There were daily and effective multidisciplinary handover meetings. Staff discussed each patient in turn giving updates from the previous 24 hours. This included changes in risk, observations, presentation, leave and visits. Additional to this, the multidisciplinary team met twice weekly, where they discussed each patient's care and treatment in detail. We observed staff to be familiar with both the patients and their families or carers. All disciplines contributed and we observed fully holistic, personalised and detailed discussions.

Nursing and support staff attended handover meetings at each shift change to ensure they were aware of the treatment requirements for each patient.

Staff from the unit developed partnerships with external organisations. For example, the teachers communicated with the patient's school to ensure on-going education.

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

Training on the Mental Health Act was mandatory for staff. There was a compliance rate across the ward of 82%. Staff had a good understanding of the Mental Health Act and the new Code of Practice 2015.

Staff adhered to consent to treatment and capacity requirements. We checked the records and found that all detained patient's receiving treatment had the appropriate legal authority attached to their medication charts. Staff carried out a weekly audit to ensure this.

Patients' records showed us that staff explained their rights under the Mental Health Act and its code of practice on admission and routinely thereafter. We saw an example of a recently detained patient with limited understanding of what was happening having their rights explained three times in one day. Staff also gave written information to the patient and their relative or carer.

The trust had a central Mental Health Act Team. Staff from the unit sent original detention paperwork to the team for checking and retained a copy in the patient's notes. Staff informed us that the central team were always available for legal advice and were quick to advise of any issues.

There were clear records detailing leave that had been granted to patients. These included risk assessments. Staff discussed leave with relatives and carers for patients under the age of 16.

Patients had access to the independent mental health advocacy services. Staff knew how to access and support engagement with the advocacy service. The trust's patient and liaison service also visited the unit on a weekly basis.

The independent mental health advisor contributed to decisions relating to renewing, extending or discharging the detention of patients.

Good practice in applying the Mental Capacity Act

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

The trust provided training on the Mental Capacity Act where staff from Mill Lodge were 94% compliant.

The Mental Capacity Act does not apply to patients aged 16 or under. For children under the age of 16, their decision-making ability is governed by Gillick competence. The concept of Gillick competence recognises that some children under the age of 16 may have sufficient maturity to make some decisions for themselves.

Are services effective?

Good

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

Mill Lodge delivered bespoke training on Gillick competency for their staff. At the time of the inspection, 69 members of staff had received the training with further programmes booked for remaining and new staff.

Staff had a clear understanding of both the Mental Capacity Act and Gillick competency. They supported patients to make their own decisions wherever possible. We saw informed consent in all the records looked at and evidence of capacity assessments done by appropriate staff. The multidisciplinary team discussed capacity and consent for each patient.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

Staff showed a caring and supportive attitude to patients. They were sensitive to their needs and showed a good understanding of the issues they faced. We observed staff interacting with patients with kindness and patience during activities; they did this in an age appropriate manner. In meetings, staff talked about patients with respect.

The involvement of people in the care that they receive

The unit invited patients to the service prior to admission where possible. Patients and relatives received a welcome pack informing them of the assessment process, the therapeutic program, visiting, meals, activities, rules and expectations, the Mental Health Act and how to complain. Consultants explained medications to the patients and gave them leaflets. One patient told us that if they were not happy about the medication they received, they felt comfortable discussing this with the staff and felt listened to.

Patients were involved in their care plans and staff offered copies. Patients did not attend their multidisciplinary meetings. Each week they completed a form to record their thoughts, their progress and their wishes. Members of the multidisciplinary team discussed these in the meetings. We saw that the patient's named nurse provided feedback to the patient following this.

The unit was keen to invite the patients into the multidisciplinary meetings however recognised this may not always be appropriate. Patient representatives attended a monthly young person's council at the service where they considered new initiatives. Their attendance at multidisciplinary meetings was due to be discussed in the next council meeting. The council meetings gave patients a voice in decisions about the service. Patients had previously used these meetings to positively discuss and agree changes in access to social media and an increase in availability of the classroom computers.

Patients also attended morning meetings. These occurred daily to discuss the day's activities and weekly to provide the opportunity to discuss issues relating to the running of the unit and suggestions for change. There was also a comment box where patients, their relatives and carers could leave anonymous suggestions.

Information about access to advocacy was included in the patient's welcome pack. Staff knew how to access this for patients if requested. However, the advocacy service used by the trust was not specifically for children and adolescents.

Families and carers were involved in the treatment and care of the patients where appropriate. We observed parents' wishes being discussed as part of a multidisciplinary meeting and as part of handover meeting relating to activities, leave and visits. It was clear that family members were familiar to staff and involved in decisions.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

Mill Lodge accepted referrals from across the UK. They had an average bed occupancy of 83% over the previous six months. NHS England funded these beds. Managers were able to consult with NHS England if they considered reducing their bed numbers or refusing an admission based on the current complexities and mix of their patients. The service did not fill a patient's bed if they were on leave. The service had not placed any young people out of the catchment area in the six months prior to our inspection.

The unit planned a patient's discharge from the date of admission and discussed in multidisciplinary meetings. Staff planned discharges to meet the needs of the patient and if discharge occurred at an evening or weekend then this was at the patient's or family's request. There had been two delayed discharges in the previous six months. One was due to a wait for a further residential placement and the other delayed by one day due to the family's request.

The facilities promote recovery, comfort, dignity and confidentiality

The unit had a good range of rooms. These included a clinic room, educational rooms, an occupational therapy kitchen, dining room, lounge area and smaller quieter areas where patients could meet visitors. There was a female specific lounge; however, staff told us this that female patients rarely used this.

Mill Lodge allowed patients to use their own mobile phones until 10pm at night if the phone was basic and did not have internet access. The unit had some mobile phones they lent to patients if required. There was also a ward phone available.

The unit had an internal courtyard giving patients access to outside space whenever they wished. It had seating areas and staff from the unit kept this area well maintained. There was a separate rear garden area suitable in size for more structured exercise sessions.

An external provider delivered meals to the unit to for staff to heat up. Patients and staff told us that they did not like the food and there was limited choice. The unit were in the process of considering alternative options for their supply of meals. Patients did have access to snacks and drinks during the day.

Patients were able to personalise their bedroom to make it feel more homely. They had a safe place to store their possessions. Staff and the patient agreed the access to their bedroom and detailed this in their care plan. The bedrooms did not have en suite facilities but all had nearby bathrooms. However, there were only showers on the unit and not baths. The bathrooms were unlocked on a night-time so patients did not have to ask staff to open them if needed.

The unit had a washing machine, though at the time of our inspection it was not working. There was a new machine on order for the service. Families mostly took washing home for the patients. For those where this was not possible, staff visited the local laundrette several times a week.

The activities co-ordinator planned activities for the week additional to the structured therapeutic sessions. This included weekends and evenings. Popular pursuits included scrap booking, pet therapy, film nights, pamper sessions and health and wellbeing groups. Staff arranged for patient's pets to visit if the patient requested this and a risk assessment was carried out.

The local authority provided teachers for two hours education per day for each school aged patient. The teachers liaised with the patient's school to deliver individual education plans. The unit had two classrooms used specifically for education. The classrooms had computers with internet access which patients were also able to access in their free time. At the time of our inspection, teachers and other staff were supporting one patient to sit for 15 GCSE examinations.

Meeting the needs of all people who use the service

The ward was on a single level, which allowed access for patients with mobility difficulties. The unit could access interpreting services if required and were able to request leaflets in other languages if required. This included leaflets relating to the Mental Health Act.

Staff from the unit recognised the needs of different people. They were able to give examples where they consulted with patients about their wishes relating to their diversity.

However, the services meal provider could not sufficiently cater for a patient's cultural needs or preferences for food.

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Staff locally sourced food for one patient who was vegan, as their supplier could not meet this need. Additionally, a patient with dietary requirement relating to their religious groups had very limited choice in their menu.

Listening to and learning from concerns and complaints

Mill Lodge had received five complaints from 1 April 2015 to 29 March 2016. The trust either fully or partially upheld four of these; they had not referred any complaints to the ombudsman. The five complaints related to communication from staff, breach of confidentiality, treatment and care and being discharged too soon.

The manager dealt with the complaints in line with the trust's policy. Staff received training on how to deal with complaints, from manager's training to customer service training for front line staff. This meant staff were able to support patients if they wished to complain.

The unit made patients aware of how to complain in their welcome pack and from information notices.

Managers discussed complaints and actions through trust governance systems. They disseminated any learning through emails, handover meetings and in supervisions.

Are services well-led?

Good

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

Our findings

Vision and values

The trust state their purpose as 'Improving Health, Improving Lives'. Their ambition was to work in partnership, aspiring to provide excellent mental health and learning disability care that supports people to achieve their goals for improving health and improving lives. The trust consulted with staff, patients and other partners to determine the following values to guide them to achieve their ambition:

- Respect and dignity
- Commitment to quality of care
- Working together
- Improving lives
- Everyone counts

Staff were generally aware of the trust's values. Senior staff informed us that they aimed to embed the values into operational practice through supervisions, meetings and appraisals. The trust included value based questions into their recruitment process.

Staff were aware of the senior managers within the trust. They told us of occasions when senior managers had visited.

Good governance

Mill lodge had effective systems in place to monitor and assess its performance. Managers used a clinical dashboard, which gave them easy and timely access to information about their service. The dashboard included performance indicators to monitor the performance of Mill Lodge at any time. This ensured managers could monitor mandatory training, supervision and appraisals for staff to be supported appropriately. The unit investigated and monitored incidents and complaints in order to improve. There were structures in place to ensure managers informed staff of lessons learnt.

Staff maximised their time on direct care activities as opposed to administrative tasks. The ward manager had sufficient authority to manage the unit and had the authority and processes in place to raise issues at trust level.

Leadership, morale and staff engagement

Staff reported a good team at Mill Lodge. Morale was reasonable high and staff felt part of one team. They received support from their colleagues, their manager and the trust. This included staff at all levels and from the varying disciplines.

Mostly staff felt empowered to input into the unit's development and give appropriate feedback. However, the change in environment following the move to Mill Lodge resulted in new staff members joining the team. One newer staff member reported to us that it was sometimes difficult to introduce new ideas to longer serving staff members.

Staff knew the whistleblowing process and said they would be able to raise concerns if the need arose without fear of victimisation. The unit had no bullying or harassment cases at the time of our inspection.

Staff were open to patients and their families and carers when something went wrong. There was a general culture of transparency with the unit actively encouraging staff to report incident in order to promote improvement. The provider had a duty of candour policy, which staff understood and demonstrated how to use it.

Commitment to quality improvement and innovation

Mill Lodge were working towards the Royal College of Psychiatrists' accreditation for in-patient child and

adolescent services, Quality Network for Inpatient CAMHS (QNIC). They had received a focussed peer review for this and received positive feedback.

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment How this regulation was not being met: • Staff did not have a full understanding of what constituted seclusion and the procedures they needed to follow when this occurred. This meant that when restrictions placed on a patient amounted to seclusion, not all of the safeguards required by the Code of Practice and the trust policy were put in place. This was a breach of regulation 13 (5)