Good

Plymouth Community Healthcare CIC

Child and adolescent mental health wards

Quality Report

Local Care Centre
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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)
1-297652203	Plym Bridge House	Plym Bridge House CAMHS in-patient unit	PL6 5ZD

This report describes our judgement of the quality of care provided within this core service by Plymouth Community Healthcare CIC, also known as Livewell Southwest. 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 Plymouth Community Healthcare CIC and these are brought together to inform our overall judgement of Plymouth Community Healthcare CIC.

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?	Good
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

Contents

Summary of findings

Overall summary

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

- The building was purpose built and well designed in terms of layout for observation and ligature risk. The building was designed with ligature free fittings, such as showers and wardrobes. There were spacious and well designed facilities to promote comfort and dignity for children and young people. All rooms were ensuite with a female only lounge and a further room that could be used flexibly to create a male lounge. The ward complied with the Department of Health guidance on same sex accommodation. There was a range of therapy rooms, a relaxation room, and games rooms and outside space. There was access to a well-designed courtyard and garden. The seclusion room was a shared facility with the children's and young people's place of safety unit, both of which were rarely used, although there was an episode of seclusion during our inspection.
- The ward was clean and well organised and there were regular environmental audits and safety checks. There were additional fire safety checks in place prior to essential building works and staff who carried these out had received up to date fire safety training.
- The service was commissioned to provide inpatient care to children and young people in the peninsula: 11 of the 12 children and young people were from the catchment area. Although the service was full with high occupancy rates, beds were always available to young people returning from leave.
- Transitional arrangements were in place for transferring young people from children's and young people's specialist services to adult in patient care services, such as eating disorders.
- Staffing levels were agreed with the specialist commissioners for the service and there were good staffing levels on each shift which could support the needs of the patient group.
- Risk assessments and care plans were detailed, and had a recovery focus. There were individual pathways, such as the eating disorder pathway and care planning included the young people's views. There was evidence of recording and updating records for obtaining consent to treatment.
- Access to psychological therapies was good including family therapy and cognitive behaviour therapy. All families were offered family therapy.
- Staff were up to date with mandatory training, including safeguarding and fire safety.
- Training in the Mental Health Act (MHA) and Mental Capacity Act (MCA) was not mandatory. Despite this we found a good understanding of MHA and MCA. Staff described good support and guidance from the Mental Health Act office. Section 17 leave records, for patients who were detained under the MHA Act were kept up to date.
- Most children and young people and all parents we spoke with reported that staff were kind, respectful and caring. There was a good rapport between some of the young people and staff. We saw positive interactions with young people. For example, the daily community group where all young people were encouraged and supported to be involved. There was reciprocal warmth between some staff and young people. The service was in the process of improving user and carer engagement in service development and there was an involvement officer in post to support this.
- The service had an effective performance management tool in place to monitor the service and there were regular reports to the specialist commissioners and there had been no recent formal complaints.

However:

- There was not a clear mechanism to learn from informal comments and complaints.
- There were gaps in the daily recording of fridge temperatures in the treatment room. Room temperatures were also not recorded to ensure the room was kept below recommended limits when storing any medicines outside the fridge.
- Staff were not confident with tasks that were carried out infrequently such as seclusion. The seclusion area was a shared facility with the children's place of safety which meant that during the seclusion there was no access to the children's place of safety unit in the area.
- Recent staff vacancies and leadership changes had affected the morale of the team and some staff did not

Summary of findings

feel confident to raise concerns. This had also resulted in some systems falling behind such as; mandatory training for some staff, and business meetings to share learning, and local and service wide information.

Summary of findings

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

Are services safe?

Good

We rated safe as good because:

- There were safe and good staffing levels to support the needs of the service.
- The ward environment was well designed to ensure that patients could be observed and kept safe.
- Safeguarding was well managed and all staff were up to date with safeguarding children and young people training.
- Staff rarely used physical restraint and were skilled in de-escalation techniques.
- Risk assessments were detailed and up to date.

However:

- One episode of seclusion had not been safely monitored and a medical examination was not recorded in line with the Mental Health Act Code of Practice.
- Staff were not always confident in supporting patients who needed extra care and seclusion, including the management and administration of rapid tranquilisation.
- Fridge temperatures in the treatment room were not consistently checked daily and room temperatures were not recorded.
- There were controlled drugs due for return to pharmacy that had not been collected for six weeks.

Are services effective?

Good

We rated effective as good because:

- Care plans were detailed and person centred and recovery orientated.
- Pathways were being developed such as the eating disorder pathway.
- There was a wide range of multi-disciplinary staff providing specialist support for children and families.
- Section 17 leave documentation was in place for detained patients on leave.
- Most staff received regular supervision and there was a range of group and individual supervision.

However:

- Mental Health Act and Mental Capacity Act training was not mandatory and there were knowledge gaps with managing aspects of the Mental health Act Code of Practice.

Summary of findings

- We observed a handover meeting between nurses. Staff did not make clear decisions as to who would take on the tasks agreed.
- Supervision meetings were not routinely recorded.

Are services caring?

Good

We rated caring as good because:

- Staff were caring and respectful.
- Carers and most patients were very positive about the care they received.
- Young people were involved in their care planning and offered copies of their care plan.
- Families felt included and involved in the care their family member received.

However:

- User and carer involvement in planning the service delivery model was not well developed.
- Carers reported that communication with staff was at times less than they would like.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- Occupancy rates were high but beds were always available to young people returning from leave.
- Transitional planning was in place for child and adolescent mental health services (CAMHS) in patient care to specialist adult in patient units, for example eating disorder units.
- The unit was purpose built, with good facilities for group and individual therapy and social and recreational space.
- Daily community groups were well managed and inclusive.
- There were good facilities for young people to prepare meals and young people's dietary needs were catered for.

However:

- Transitional care arrangements were not developed for young people moving to the local adult community mental health team (CMHT) services due to the pressure on the local CMHT services.
- Arrangements to monitor informal comments and complaints were not robust.

Are services well-led?

Good

We rated well-led as good because:

Summary of findings

- There were good governance systems in place to monitor the service.
- The service was developing systems to improve supervision and training and user participation in service design and involvement.
- The unit was a member of the Quality Network for Inpatient CAMHS.

However:

- Some staff were not familiar with the overall visions and values of the organisation.
- Recent staff changes had affected morale and there was a mixed response in how confident staff would feel to raise concerns.

Summary of findings

Information about the service

Plym Bridge child and adolescent unit is a purpose built 12 bed inpatient mental health ward for young people requiring inpatient admission who live in Devon, Cornwall and the Isles of Scilly. The unit opened in 2011.

Young people can be admitted informally, by parental consent (if under 16) or detained under the Mental Health Act. The unit is mixed sex and treats young people aged between 12 and 18. They provide 24 hour specialist psychiatric care and treatment for those with a variety of mental health difficulties, which can include anxiety, depression, eating disorders and psychosis.

The unit has an on-site place of safety facility and education facilities. The education facilities were inspected by the office for standards in education, children's services and skills (Ofsted) in November 2013 and received a rating of good.

The service was inspected by CQC in December 2013 and met the five standards inspected which were in relation to consent to care and treatment, care and welfare, cleanliness and infection control, supporting workers and records.

Our inspection team

Our inspection team was led by:

Chair: Andy Brogan, executive director of nursing, South Essex Partnership Trust

Head of Hospital Inspections: Pauline Carpenter, Care Quality Commission

Inspection manager: Nigel Timmins, Care Quality Commission.

The team that inspected the core service comprised of an inspector, a pharmacy inspector, a senior nurse specialist advisor and an approved mental health practitioner advisor.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the service and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited the inpatient unit at Plym Bridge House and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with three patients who were using the service and collected feedback from one young person using comment cards
- spoke with three young parents or carers of young people
- spoke with the manager for the ward
- spoke with the matron for child and adolescent mental health services
- spoke with four other staff members; including a psychiatrist, psychologist and nurse

Summary of findings

- attended and observed a hand-over meetings and a multi-disciplinary meetings
- looked at six treatment records of patients
- reviewed nine medicines charts
- carried out a specific check of the medication management on the ward
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We spoke with three parents and carers and three young people and collected a comment card from one person. Most people were positive about the service and described staff as helpful and caring.

Young people told us that they were included in planning their care and that their views were included in their care plans. We saw evidence of this in the care plans we reviewed.

We received negative comments from one young person about some staff. We also received two negative comments about the quality of food delivered to the unit at lunchtimes.

Carers were positive about the service and told us that staff were supportive, kind and non-judgmental. However, there were comments that frequency of communication needed to improve at times.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that staff are familiar with task that are undertaken infrequently i.e. rapid tranquilisation and the use of seclusion to ensure that when required staff were skilled to deliver the necessary intervention.
- The provider should ensure that the clinical room fridge temperatures are recorded daily to ensure it is within the correct temperature range.
- The provider should log room temperatures in the clinic room to ensure that ambient temperature drugs are stored within the correct temperature range.
- The provider should ensure that all medicines are collected and disposed of safely within agreed timeframes.
- The provider should ensure that all staff complete mandatory training.
- The provider should identify which staff require essential MHA training and keep a record of their attendance.
- The provider should display notices next to locked exits and entrances explaining the rights of informal patients on the unit to leave the premises.
- The provider should ensure that transfers take place at a suitable time of the day.

Plymouth Community Healthcare CIC

Child and adolescent mental health wards

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Plym Bridge House	Plym Bridge House 4 William Prance Road Crownhill Plymouth PL6 5ZD 1-297652203

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.

Young people can be admitted informally, by parental consent (if under 16) or detained under the Mental Health Act. There were two patients that were detained under the Mental Health Act.

Staff we spoke to demonstrated an understanding of the Mental Health Act and described good support from the central administration Mental Health Act team. However, Mental Health Act and Code of Practice training was not mandatory for staff. There were some knowledge gaps with managing aspects of the Mental Health Act Code of Practice.

There were copies of leave forms and consent to treatment forms on file, copies of the detention papers were kept at the MHA office and scanned copies were kept on file.

Mental Capacity Act and Deprivation of Liberty Safeguards

No young people aged over 16 were subject to the Mental Capacity Act at the time of the inspection.

Detailed findings

Staff demonstrated a good understanding of Gillick and Fraser competence and obtaining consent to treatment. However, training for understanding the Mental Capacity Act was not mandatory and training rates were not actively monitored.

Good

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

- The ward was purpose built with a layout that allowed full line of sight to the bedrooms. In addition, the bedroom lights came on automatically when patients left their bedrooms.
- There were minimal ligature points in non-patient areas, such as in the art room and on taps in the patient's laundry room. These were adequately mitigated as patients did not attend these areas without staff.
- The ward was a mixed sex ward that complied with guidance on same sex accommodation. Each room was anti ligature and had ensuite wet rooms with anti-ligature taps. The wet rooms varied in size and some were quite small. Three of the young people commented negatively about the size of the bathroom facilities and the difficulty of keeping their possessions dry when using their bathroom.
- There was a female only lounge. On the first day of our visit there were only female patients. When there had been male patients we were told that the games room had been converted to a male only lounge.
- There was a fully equipped clinic room with accessible resuscitation equipment to fit children and adults. The emergency drugs were checked regularly.
- The seclusion room was part of an extra care area; this was a shared facility with the place of safety for children and young persons in Plymouth, Devon and Torbay. Access to the Plym Bridge place of safety was through a separate entrance. Both facilities were rarely used and seclusion had not been used in the last two years. We were told that seclusion and use of the place of safety did not take place at the same time, therefore; when the place of safety suite was in use there was no access to seclusion facilities.
- The seclusion room allowed clear observation, two way communication between the patient and staff, it had toilet facilities and there was a clock that could be seen when the seclusion room was being used.
- On the second day of our visit, the unit admitted a patient who was being nursed in the seclusion facility. This meant that there was no access to a children's place of safety in Plymouth, Devon and Torbay for this five day period.
- During the intervention, staff found that some of the furnishings in the seclusion room were not fit for purpose as they did not meet the safety standards of furnishings for a seclusion room. This was removed from the seclusion room to maintain the safety of the patient and staff.
- All ward areas looked clean, had good furnishings and were well maintained. Carers spoke positively about the cleanliness and one carer commented that the unit was always spotlessly clean. However, one young person told us that their room was not regularly cleaned, although we were not able to substantiate this.
- All cleaning cupboards had self-locking doors and there were up to date cleaning checklists and health and safety audits demonstrating that the environment was safe and regularly cleaned. There were regular health and safety self-assessment audits.
- The unit was a standalone unit with community staff offices upstairs. All bedrooms and bathrooms had alarms with call buttons. The ward staff also carried alarms.

Safe staffing

- Staffing levels were safe. Safe staffing levels were set by NHS England as part of their specialist commissioning arrangements. Additional staff, funded by the commissioners were in place to cover the onsite place of safety unit. There were also teaching and occupational therapy staff on weekdays.
- However, turnover was at 8% in the year leading up to March 2016 and there had been recent nursing staff vacancies and sickness. Staff nurse posts had recently been advertised.
- We reviewed a sample of the duty rota which confirmed that the number of nurses planned matched the number of staff on duty. There was some use of agency and bank nurses. The majority of agency and bank staffing was block booked through NHS professionals who were familiar with the ward.

Good

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- A registered nurse was present in communal areas of the ward at all times and there were enough staff for patients to have regular one to one time. Each young person was allocated a small team consisting of a primary nurse, secondary nurse and a health care assistant.
- There was adequate medical cover at night and a doctor could attend the ward quickly in an emergency. There was also a specialist CAMHS consultant on call after 5pm and at weekends. During our inspection a patient was admitted who required seclusion and was seen by the duty doctor at night in a timely way. However, additional medical reviews did not take place in line with the mental health act code of practice during the day. There was no record of a formal medical review during the day on the seclusion record or system one which was the electronic patient record. However, the ward took action to rectify this during our visit.
- Staff were trained in safeguarding and knew how to make a safeguarding alert when appropriate. Staff knew who the safeguarding leads were and were compliant with safeguarding training in adults and children. The unit was in the early stages of rolling out safeguarding passports for staff to support reflective practice and learning from safeguarding incidents.
- Safeguarding training compliance rates were high with all staff up to date with level one and two of safeguarding children. Most staff had completed the training, 91% of applicable staff had completed level 3 safeguarding training and 95% of all staff had completed safeguarding adults training. The unit had recently introduced a learning passport for staff undertaking level 3 safeguarding which included a template for staff to reflect on their learning.
- The building was recently assessed as not being built to full fire safety standards. As the provider leased the building additional staffing had been funded by the lease holder to provide staffing for additional fire safety checks at night until essential maintenance work had taken place to ensure that the building met the current fire safety standards. This approach had been agreed with fire safety officers and specialist commissioners until the works were completed. All staff involved in fire safety checks had completed recent fire safety training.

Assessing and managing risk to patients and staff

- The overarching principle of the unit was to provide care and treatment for young people in the least restrictive way for the minimum amount of time. There were no incidents of restraint in the last twelve months leading up to the inspection. There were also no incidents of seclusion or long term segregation in the last 12 months leading up to the inspection. There was one episode of seclusion during our inspection.
- The unit was well staffed and staff were confident in anticipating, preventing and de-escalating situations before incidents arose. Most staff had received recent physical intervention training that included de-escalation and restraint. There were up to date policies that staff were aware of that included managing seclusion and managing physical interventions safely with the minimum amount of restraint.
- On the day of the inspection the seclusion room was being used. This was the first time in two years the room had been required and staff were uncertain about the use of rapid tranquilisation and seclusion. We witnessed delays in preparing and administering prescribed rapid tranquilisation and there were delays in carrying out formal medical reviews during the seclusion period.
- A few restrictions were in place, we saw records of why these were in place and found that they were being managed appropriately. For example, bedroom doors were locked during the day to encourage patients to have a therapeutic daily routine. However, patients could request a change to this and we were given examples where this was assessed on an individual basis. We did not find evidence of the use of blanket restrictions.
- Informal patients were free to leave at will and were aware of this. However, no notices were displayed that explained the rights of informal patients on the unit and ward. There were also no notices explaining patient's allowed leave near to the locked external and internal ward doors.
- There were good policies and procedures for use of observation and consent was obtained for observation and treatment.
- We reviewed six risk assessments and saw that these were detailed and updated regularly. Risk assessments were individual and linked to a detailed care plan.
- The clinic room was clean and medicines were stored securely in the clinic room. The emergency resuscitation equipment was kept in the clinic room and we saw evidence of daily checks.
- We reviewed nine prescription charts and saw that any omitted doses were clearly recorded and there were no

Good

Are services safe?

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gaps in recording. Prescriptions were well written and signed and dated and prescribing was within the British National Formulary for dosage ranges for children and young people.

- There were medicine audits in place, such as regular audits for omitted doses carried out by the pharmacy team.
- Staff reported that they could contact the pharmacist by phone regularly and clinical pharmacy visits took place once a week. There was no access to additional support such as a pharmacy technician and pharmacists did not attend multidisciplinary meetings.
- The pharmacist's role included the collection of medication for disposal; however, there were controlled drugs stock that was waiting for return to the provider pharmacy for six weeks.
- Fridge temperatures in the clinic room were monitored and recorded regularly and were within the required temperature ranges. However, they were not recorded daily and there were frequent gaps and omissions in May and June 2016. The clinic room temperature was also not recorded, although the room did not appear warm.
- There were procedures for families and children to visit the unit, such as a family room and use of interview rooms for visits.

Track record on safety

- There were no serious incidents in the last 12 months. There were incidents of self-harm that were recorded and reported and these were logged with the risk team. All staff could update the risk log.

Reporting incidents and learning from when things go wrong

- All staff knew we spoke with were confident with reporting incidents. Staff discussed feedback from investigation of incidents both internal and external to the service and all staff had access to a regular SIRI newsletter with details of learning from serious incidents. The SIRI policy clearly described the provider role of openness and transparency as part of their duty of candour which staff were aware of.
- Staff described learning from a serious incident 18 months ago.
- Staff met to discuss feedback at team meetings and were offered support and de-briefing after incidents. This took place following an incident during our visit.

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

- Care records were up to date, personalised, holistic and recovery oriented.
- We looked at six care plans and saw that there were comprehensive and timely assessments completed after admission. All care records showed that a physical examination had been undertaken and that there was ongoing monitoring of physical health problems.
- Care plans were detailed for each patient and were written in a style that was easy to follow for managing the care needed for each individual. Care plans showed that patient's views were listened to and young people's views and hopes were incorporated into the plans. Care plans were recovery orientated. Children and young people were offered copies of their care plans.
- All care plans were stored securely on the service wide electronic system.

Best practice in treatment and care

- Patients had access to a range of psychological therapies such as family therapy, cognitive behavioural therapy and dialectical behavioural therapy. There was an eating disorder pathway in place.
- Care was evidenced based and the service followed guidance, such as National Institute for Health and Care Excellence. For example in the treatment of depression and eating disorders.
- The unit completed Health of the Nation Outcome Scales Children and Adolescents and Children's Global Assessment Scale to assess and record severity and patient outcomes and records showed that this took place within two weeks of admission. These tools were used to measure any improvement in a patient's wellbeing while in a CAMHS unit.
- There were regular audits such as child protection records, equipment, and sharps audits. There were regular fire safety audits.
- There was good access to physical healthcare and nutritional support, including access to specialists such as a dietician who attended the weekly multidisciplinary meeting.

Skilled staff to deliver care

- There was a range of mental health disciplines and workers providing input to the ward. This included an occupational therapist, family therapy and psychology staff in addition to nurses and doctors and a dietician. The consultant psychiatrist also practiced as a family therapist. All families were offered family therapy. There was no social worker on the team.
- Staff were experienced and qualified and had access to specialist training, for example family therapy training and legal frameworks such as the Children Act for all registered staff.
- Most staff had regular clinical supervision and 97% of staff received regular supervision. Supervision meetings usually took place bi-monthly which met the current clinical supervision policy to provide regular supervision. Additional supervision was provided, such as monthly nursing group meetings and monthly health care assistant supervision meetings. However, supervision meetings were not routinely recorded.
- . The clinical supervision policy stated that clinical supervision was not necessarily documented in an individual's files and was an agreement between clinical supervisor and supervisee. This was in the process of being updated to include record keeping of the sessions.
- As part of the service wide revalidation arrangements for protected time for staff to complete specialist and mandatory training was being introduced.
- Most staff had received a recent appraisal and 91% of non-medical staff had received an appraisal in the last year.

Multi-disciplinary and inter-agency team work

- The multidisciplinary team on the ward included a psychiatrist, psychologist, nurses, health care assistants, a family therapist and an education team.
- We observed the weekly multidisciplinary meeting which consisted of a range of these staff. Patients' individual plans were discussed in detail and this included information about risk, physical health monitoring, leave arrangements and patient outcomes.
- We observed a handover meeting between nursing and health care assistant staff. Information from the multidisciplinary team was discussed. However, issues and risks that were flagged at the meeting were not clearly assigned to nursing staff during the handover.
- There were good links with other teams, for example, community psychiatric nurses and local authority social services who were invited to attend CPA reviews and discharge planning meetings. However, staff reported

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.

that this did not always work as well for patients that lived outside the Plymouth area. In these instances staff reported that there were regular liaisons by phone and email.

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

- Mental Health Act and Code of Practice training and refresher training was not mandatory for staff. Training rates were not actively monitored. However, staff we spoke to showed an understanding of the key aspects of the Mental Health Act and demonstrated an understanding of Gillick competence as described in the Mental Health Act Code of Practice.
- However, there were gaps in managing some aspects of the Mental Health Act Code of Practice, such as rapid tranquilisation and the management of seclusion.
- Administrative support and legal advice on implementation of the Mental Health Act and its code of Practice was available from a central team. Staff described good support and advice from the Mental Health Act administration office.
- There were two patients that were detained under the Mental Health Act at the time of our inspection. We reviewed the section 17 leave documentation. There was evidence that forms had been signed and leave records were up to date. Scanned copies of all detention papers were kept electronically on the patient files.
- Children and young people's capacity for treatment was assessed. Assessment of capacity and consent had taken place for formal and informal patients. Consent to treatment and capacity requirements were adhered to. We saw that a copy of consent to treatment form was attached to the medication chart.
- The unit provided independent mental health advocates for all qualifying patients on the unit and there were posters on the unit with information on how to contact advocates.
- The Mental Health Act manager reported on the activity of all detentions under the Mental Health Act.

Good practice in applying the Mental Capacity Act

- The Mental Capacity Act applies to young people aged 16 or over. For children under the age of 16, the young person's decision making ability is governed by Gillick competence. The concept of Gillick competence recognises that some children may have sufficient maturity to make some decisions for themselves.
- No patients aged 16 or over were assessed as requiring the protection of the Mental Capacity Act at the time of the inspection.
- Assessments of capacity and consent were discussed and logged at the weekly multidisciplinary 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. A presumption of capacity was made and individuals were supported make their own decisions where possible. In care plan and multidisciplinary discussions staff considered the least restrictive option in discussion of patients who lacked capacity.
- Training for understanding the Mental Capacity Act was not mandatory for staff and training rates were not actively monitored. Staff were unclear as to how mental capacity adherence in the unit was monitored. However, staff demonstrated a good understanding of Gillick and Fraser competence and obtaining consent. For example, in seeking consent for observations.

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

- We saw that staff were kind, respectful and provided appropriate practical and emotional support in most instances. In our observation of the community meeting there was empathy, warmth and reciprocal respect and humour. One staff member had helped to plait some of the young female patients' hair which young people were positive about.
- One young person expressed dissatisfaction about some staff. We reported a concern raised by a patient about a staff member talking rudely to a patient and the manager took appropriate action. However, the majority of reports by young people and their parents and carers of how staff treated them were very good.
- Carers told us that staff were kind, non-judgemental and were always respectful. They expressed satisfaction with the care that their child received.
- However, two carers and one young person described communication issues, such as mixed or conflicting messages from staff.

The involvement of people in the care that they receive

- There was active involvement and participation in care planning and risk assessments and this was evidenced in the six care plans we reviewed. Patients were offered a copy of their care plan. Patients and their families were included in care programme approach review meetings and discharge planning. However, we did not see any patient or carer participation in the weekly multidisciplinary discussions about patient care.
- For planned admissions the young people and their families were shown around the unit prior to admission. Each person was given a ward handbook which explained the ward routine and included general information that young people and their carers may need during their time on the ward.
- Young people were able to get involved in the running of the service, such as in interviews for new staff. There were opportunities to be involved in the day to day running of the service through the community group.
- The CAMHS service had recently involved a participation lead to support young people in getting involved in the development of the service. However, the implementation of a carers group had not been successful, staff advised us that this was due to challenges such as travel distances for carers as the service was Peninsula wide, covering Devon, Cornwall and the Isles of Scilly.
- Staff facilitated the involvement of families and carers in their child's treatment via regular phone calls, updates and family therapy sessions. All families were offered family therapy. Family visits were encouraged to take place.
- People were able to give feedback on the service they received though community meetings and other forums. For example there was a suggestion box on site which was monitored weekly. Friends and family tests were completed on discharge and user and carer satisfaction was fed back to the team.

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

- There were 12 beds for children and young people at Plym Bridge House. The catchment area for the beds was the Peninsula geographical area, covering Devon, Cornwall and the Isles of Scilly. At the time of our visit the unit was full. There was some provision for accepting extra contractual referrals of young people from outside of the Peninsula but the unit was purpose built as a local facility.
- Bed occupancy rates were high and were reported as 96% between July 2015 and June 2016. There was always access to a bed on return from leave and leave beds were not allocated to another patient. This was a commissioning agreement.
- Beds were allocated according to clinical need, primarily for the peninsula area. Most patients on the unit lived in the local catchment area. However, one patient was discharged home on the first day of our inspection and an out of area patient was transferred from another unit that evening.
- Staff were aware of the need to carefully plan the transition from child to adult services and planning took place. For example, the unit was in the process of transition planning for a young person to move to a specialist inpatient eating disorder service. There were concerns raised that the adult community mental health services in the Plymouth area, in particular, did not have the capacity to be involved if they needed to plan the transition of young person to the adult community services. Safe and effective transition from community CAMHS to Adult Mental Health Services (AMHS) was a current commissioning quality and innovation target.
- The aim of the unit was to provide a short stay environment for three months and the average length of stay for patients between July 2015 and June 2016 was four months at 122 days.
- There were two patients whose discharge was delayed for non-clinical reasons in the six months up to the end of January 2016; this was due to delays in obtaining social care placements or social care support. During our inspection the staff confirmed that there were two delayed discharges for patients waiting for social care plans. Delayed discharges were reported to the specialist commissioners.
- When people were admitted or discharged, staff confirmed that this happened at an appropriate time of day and we saw that this took place with a discharged patient. However, this did not happen consistently with patients who were being transferred into the unit. For example, one young person was transferred from the local acute trust after midnight and during our inspection the ward accepted a transfer of a patient who arrived in the evening.

The facilities promote recovery, comfort, dignity and confidentiality

- The unit was purpose built and there was a range of rooms used for therapy and education including an art room, education room and group room. There were quiet areas, including a quiet room and a female only lounge. There was a family room and other private clinic rooms for young people to meet families.
- Young people were able to personalise their bedrooms and bring in their personal items. Bedrooms were personalised with patients own quilt covers, posters and photographs.
- There was somewhere secure for young people to store their possessions and each room had a locked safe. In addition each patient had a locked cabinet outside their bedroom where they could store personal items safely, such as hair straighteners and nail scissors.
- In the occupational therapy kitchen each young person had a designated drawer for their own snacks; this was where young people could have access to make hot drinks with staff.
- Mobile phones with cameras were not permitted. There was a policy and information about use of mobile phones on the ward. However, children and young people could make phone calls using the ward cordless phone and could text family and friends using the ward mobile. For patients who brought in their own mobile phones, these were stored securely. Usage was not routinely permitted. Patients were risk assessed and mobile phones could be used in a limited way with close supervision
- There was some access to the internet which was monitored and restricted for each young person. Gaming devices that did not connect to the internet or have cameras were permitted.
- There was age appropriate health promotion material, such as healthy eating and exercise. Young people were offered support with smoking cessation if they wished.

Are services responsive to people's needs?

Good

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

For young people that wished to continue smoking there were agreed smoking breaks where staff would accompany the young person to a designated area off the ward.

- At lunchtime, staff and young people sat together to eat their meal. Four young people commented on the food and the food choices. Two young people were neutral about the food but two were negative about the quality of the food provided, particular the lunchtime menu. There was also a negative review of the food on the NHS choices website on May 2016. The service had discussed food quality and choices at community meetings and had involved young people in decisions. For example, in making menu changes and preparing meals. Young people were encouraged to prepare snacks and meals.
- There was a therapeutic programme of school and group work during the week with activities in the evenings and at weekends which were decided and agreed with the young people.

Meeting the needs of all people who use the service

- The service had full disabled access and had been awarded a five star rating of disabled access and facilities by 'Disabled go' which was an access guide for the locations accessibility using access icons and other information regarding access.
- Information leaflets were available in languages spoken by people who use the service and were ordered though language line. Staff supported families where English was a second language. There was easy access to translation services and interpreters.
- There was accessible information on local services, patients' rights and how to comment and complain. There was a range of information and leaflets designed to protect young people's rights such as information about local advocacy and Routeways, which was an equal voices group to support young people and help them to have a voice in their care and treatment.
- The service provided a choice of food to meet dietary requirements of religious and ethnic groups. There were well organised fridges with separate compartments for those with dietary requirements such as a vegan diet and lactose intolerance.
- There were designated snack times with a focus on healthy eating and fruit was available at all times.
- There was access to spiritual support from the chaplaincy and spiritual care team. Young people were supported to attend places of worship and churches if requested.

Listening to and learning from concerns and complaints

- We reviewed two complaints made in August 2015 and saw that these were appropriately reported and investigated. There was evidence of duty of candour with an apology and evidence of learning from the complaints. There had been no formal complaints since this date.
- There was information around the unit on how to complain and young people were supported to complain. The service met with young people and families if they wished to complain in an informal way and to promptly resolve any issues. If this was not resolved then this would be escalated to the formal complaints process. However, this was not recorded on a log so it was unclear how many informal complaints there had been and learning arising from this.
- There was access to the Patient Advice and Liaison Service and the customer care department at Mount Gould head office. Carers we spoke with told us that they would ask staff how to complain formally if they needed to.
- Children and young people were supported to complain through several routes including a suggestion box, community groups, Routeways and advocacy.
- Staff we spoke with knew how to handle formal complaints appropriately and received feedback on the outcome of complaints investigations. There had been no recent formal complaints. Staff also received the SIRI newsletter with details of serious incidents and actions to act on the findings.

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

- Staff were committed to working with children and young people and all staff we spoke to enjoyed their work. Staff were familiar with the overarching principles and values of the unit but there was little awareness of the overall organisational values which was highlighted as an issue in the 2015 staff survey.
- Staff were familiar with who some of the senior management team were and some staff recalled a visit by the chief executive.

Good governance

- Safeguarding training compliance rates were high. Compliance with mandatory training was monitored and reported on each month and there was a system to remind staff to book on to training. MHA and MCA was not mandatory and was training in this area was not monitored routinely.
- Plym Bridge house was below the provider's compliance rate for mandatory training. Managers were aware of this and monitoring of mandatory training was being improved to include training passports to support professional practice but this was not embedded at the time of our visit.
- There were systems in place for the service to monitor staff appraisal rates.
- Staffing levels were monitored and sufficient staffing covered shifts. These met the safe staffing requirements of the commissioners. This was monitored as part of the monthly performance reporting to the Board.
- There had been no recent incidents but there was an "open culture" for incident reporting and learning from investigations, for example the SIRI newsletters were shared and complaints were shared.
- However, whilst there were informal staff meetings and staff discussions we did not see any recent minutes of business meetings where complaints, incidents and user feedback were disseminated to the wider multidisciplinary team. The service manager who had been in post for less than two weeks was aware of this and was in the process of starting a formal minuted meeting.
- Young people were involved in interview panels for staff but involvement of young people and carers in the planning and delivery and design of the service, such as a website and leaflets was in the early stages.
- There were clear performance indicators for reporting. The Quality Effectiveness & Safety Trigger Tool included information on a range of performance indicators with a RAG rated scoring system to trigger when there were issues, such as training rates below 90% or sickness rates above 3.5%.

Leadership, morale and staff engagement

- Morale and staff engagement was mixed across the staff team. There were recent changes in the leadership of Plym Bridge unit and recent vacancies in the core nursing team. The gaps in management and recent changes in service leads had adversely affected the morale of the multi-disciplinary team and created some uncertainty and confusion. However, the new service lead that had been in place for two weeks appeared to have had a positive impact on the team.
- The recent management changes had not been fully understood by the staff team which had left some staff uncomfortable to raise concerns if needed.
- There were good opportunities for leadership development with links to the local university leadership course, There was also an external leadership programme in place via the children's and young person's Improving Access to Psychological Therapies programme.

Commitment to quality improvement and innovation

- The service participated in the Royal College of Psychiatrists' quality network for inpatient CAMHS. The Quality Network was developed to both demonstrate and improve the quality of inpatient child and adolescent psychiatric inpatient care through a system of review. The network carried out a peer review in March 2015 at Plym Bridge house in relation to the environment and facilities, staffing and training, access, admission and discharge, care and treatment, information, consent and confidentiality, young people's rights and safeguarding children and clinical governance. The service had received an overall good review and was implementing the action plan where issues were identified, for example, in relation to staff management.