

# Southern Health 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)
RW146	Trust HQ	Bluebird House	SO40 2RZ
RW121	Leigh House	Leigh House	SO21 1HD

This report describes our judgement of the quality of care provided within this core service by Southern Health 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 Southern Health NHS Foundation Trust and these are brought together to inform our overall judgement of Southern Health 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

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

#### **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

Significant improvements had been made to the child and adolescent mental health wards since the October 2014 inspection and the trust had addressed the previous compliance actions. At the October 2014 inspection, we found high levels of staff commitment and enthusiasm in Bluebird House, where young people were involved in all aspects of their care and support. At this inspection in January 2016, we found this was again the case and Leigh House had worked hard to achieve the same high standard.

There were now trust policies in relation to the restraint of young people. Young people were involved in all aspects of planning their care and treatment at Leigh House. Young people had routine health checks in Bluebird House and Leigh House. There was a trust transition policy to support young people transitioning into adult services, and clear care pathways for young people. The discharge of young people was discussed or planned as part of the admission to the service. The staff team ensured that young people at Leigh House did not feel that the service was planned around the needs of the young people with an eating disorder, and that those

with mental health needs received the same level of support. Staff in Bluebird House and Leigh House were aware of any trust-wide initiatives to seek feedback from young people and other users of the services or staff.

However, from information provided by the trust, there was a large amount of prone restraint (face down) occurring at Bluebird House. There was a training request for staff to train in supine restraint (face up) submitted in September 2015. During inspection, we were advised that training would be rolled out to staff from April 2016. The trust has since told us that it is developing a programme “which will see staff trained in a variety of different restraint techniques including supine with the main focus being on reducing the frequency of restraint and its duration when used” and as such the training package will not be implemented in April 2016. Out of hours medical cover was not consistently available at Bluebird House. There were no suitable arrangements to ensure that the trust was made aware of incidents involving a young people’s first medical review, when seclusion was authorised had not been undertaken by the responsible clinician or duty doctor (or equivalent) within one hour of the commencement of seclusion.

# Summary of findings

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

### Are services safe?

We found the following issues that need to improve:

There was a large amount of prone restraint (face down) occurring at Bluebird House. There was a training request for staff to train in supine restraint (face up) submitted in September 2015. During this inspection, the trust advised that training would be rolled out to staff from April 2016. The trust has since told us that it is developing a programme “which will see staff trained in a variety of different restraint techniques including supine with the main focus being on reducing the frequency of restraint and its duration when used” and as such the training package will not be implemented in April 2016.

- Out of hours medical cover was not consistent. Neither the responsible clinician nor the duty doctor (or equivalent) carried out the young people’s medical review within one hour of the start of seclusion, as outlined in the Code of Practice: Mental.
- The staff team at Bluebird House did not ensure that records of episodes of seclusion always included the length of the seclusion and the time the seclusion ended.
- The staff team did not ensure that

However, we also found the following areas of good practice:

- The policies and procedures in relation to restraint had been reviewed by the trust in line with national guidance in relation to the restraint of young people. In Leigh House, there were appropriate levels of staff on duty, trained in restraint, to ensure the safety of young people in the event of an incident.
- The policy relating to seclusion complied with the Mental Health Act Code of Practice.
- Staff reported incidents appropriately and these were monitored by senior managers.
- The matrons in both Leigh House and Bluebird House ensured that ligature risks were appropriately identified and managed. A **Ligature** point is anything that could be used by the young people to attach a cord, rope or other material for the purpose of strangulation.

### Are services effective?

We found the following areas of good practice:

# Summary of findings

- The matrons at both Leigh House and Bluebird House ensured that the mental capacity of young people was assessed and consent was recorded. The staff had training in relation to the use of the Mental Capacity Act 2005 with young people, or of the Gillick Competencies.
- Staff at both Leigh House and Bluebird House, had assessed each young person's needs before and on admission to the service. They also carried out physical health checks and recorded the results in patients' care plans.
- Staff followed national guidance and best practice tools when designing and delivering care packages for young people.
- The young people had access to a wide range of therapies in both houses.
- There was multidisciplinary working across the services and young people were invited to reviews about their care.
- All of the staff we spoke with were provided with sufficient training and development to keep them up-to-date with their practice. A training request has been submitted in relation to restraint.
- However, we also found areas that the service provider could improve:
- There were not suitable arrangements in place to obtain the consent of patients in relation to treatments such as psychological interventions in Moss and Stewart wards in Bluebird House.

## Are services caring?

We did not fully inspect this key question because we rated it as rated good at the October 2014 inspection. However, we found that the staff teams in both Leigh House and Bluebird House ensured that young people were involved in decisions made about their care and treatment.

## Are services responsive to people's needs?

We did not fully inspect this key question because we rated it as good at the October 2014 inspection. However we found staff responded to complaints by young people or their families and discharge planning took place as part of the admission of young people to the service.

## Are services well-led?

We did not fully inspect this key question because we rated it as good at the October 2014 inspection.

# Summary of findings

In both Leigh House and Bluebird House staff and young people were complimentary about the managers and spoke positively about the impact they had made on each ward.

# Summary of findings

## Information about the service

The adolescent inpatient and forensic services of Southern Health NHS Foundation Trust provide inpatient services to children and young people aged from 12 to 18. The service falls under the mental health directorate. The trust has two locations serving young people's mental health needs. These are Bluebird House and Leigh House.

Bluebird House is a purpose-built, medium secure inpatient unit that specialises in the treatment of emerging personality disorders. Hill, Moss and Stewart are its three wards. It is on the site of the trust headquarters at Tatchbury Mount. Leigh House is an acute adolescent inpatient unit providing up to 20 beds for patients experiencing severe and complex mental health difficulties. The service has specialist expertise in treating young people with eating disorders.

The last inspection of the adolescent inpatient and forensic services of Southern Health NHS Foundation Trust took place between the 7 and 10 of October 2014 published in February 2015, the trust received five requirements as we found it to be in breach of the Health and Social Care Act (2008) in five areas:

- Regulation 11 safeguarding people who use the services from abuse
- Regulation 22 staffing
- Regulation 9 care and welfare of people who use services
- Regulation 18 consent to care and treatment
- Regulation 17 respecting and involving people who use services.

We told the trust that:

- The registered provider must have suitable arrangements in place to manage the restraint of young people. There were no trust policies in relation to the restraint of young people. The records relating to restraint did not demonstrate that this was always managed appropriately.
- The registered provider must have suitable arrangements in place to ensure the welfare and safety of young people. The trust seclusion policy did

not provide clear information in relation to the use of seclusion of young people. The records relating to seclusion did not demonstrate that periods of seclusion were always managed safely. The management of young people nursed on close observations, and general observations were not robust or recorded appropriately to demonstrate that young people were appropriately monitored.

- The registered provider must have suitable arrangements in place to ensure enough suitably qualified and skilled staff were on duty at all times. At Leigh House there were three staff on duty during the night. Across the staff team, not all staff employed were trained in the use of restraint. This meant that patients' needs could not be adequately met in the event of an incident.
- The registered provider must have suitable arrangements in place to obtain the consent of service users in relation to the care and treatment provided. There were no trust policies in relation to consent for children and young people. The staff did not demonstrate a clear understanding of their responsibilities in relation to the Mental Capacity Act 2005 or Gillick Competencies, which meant that capacity and consent for young people was not appropriately captured.
- The registered provider must have suitable arrangements in place to ensure that young people were involved in all aspects of planning their care and treatment.

Following the inspection conducted in October 2014, we also told the trust that :

- The registered provider should ensure that health checks are carried out routinely.
- The registered provider should ensure that young people at Leigh House are encouraged to be involved in the care planning or reviews about their care.
- The registered provider should ensure that there is a trust transition policy to support young people



# Summary of findings

transitioning into adult services, or clear care pathways for young people. The discharge of young people was not discussed or planned as part of the admission to the service.

- The registered provider should ensure that young people at Leigh House do not feel that the service is planned around needs of the eating disorder specialism, and that those with mental health needs receive the same level of support.

- The registered provider should ensure that staff are aware of any trust-wide initiatives to seek feedback from young people and other users of the services or staff.

- Summary of findings

Leigh House and Bluebird House had met all the requirements of the October 2014 inspection.

- At this inspection in January 2016 Bluebird House was in breach of Regulation 12.

## Our inspection team

The inspection team was led by:

Team Leader: Karen Bennett-Wilson, head of inspection for mental health, learning disabilities and substance misuse, Care Quality Commission

The team comprised three Care Quality Commission (CQC) inspectors and a Mental Health Act (MHA) reviewer.

## Why we carried out this inspection

In January 2016, the Care Quality Commission carried out a short notice, focussed inspection of Southern health NHS Foundation Trust.

Following the publication of the Mazars report in December 2015 CQC announced that it would undertake an inspection of the Southern Health NHS Foundation Trust early in 2016.

The Mazars report, commissioned by NHS England, details the findings of an independent review of the deaths of people with learning disability and mental health problems in contact with the trust between April 2011 and March 2015. The report described a number of serious concerns about the way the trust reported and investigated deaths, particularly of patients in older person's mental health and learning disabilities services. It also identified that the trust had failed consistently and properly to engage families in investigations into death of their loved ones.

In response to the publication of the Mazars report the Secretary of State requested that we:

- review the trust's governance arrangements and approach to identifying, reporting, monitoring, investigating and learning from incidents; with a particular focus on deaths, including ward to board assurance and
- review how the trust was implementing the action plan required by Monitor.

In addition, we wanted to check whether the trust had made the improvements that we had told it to make following the comprehensive inspection in October 2014 and the focussed inspection of the learning disability services at the Ridgeway Centre, High Wycombe and the forensic services, which we had carried out in August 2015. We had also received a number of complaints about some of the trust services, had contact from a number of whistle-blowers (people who expose activity or information of alleged wrong doing in a private or public organisation) and had identified a high suicide rate in the Southampton area.

As such, this inspection focussed on mental health and learning disability services delivered by the trust, in particular;

- mental health acute inpatient wards (all 4 units)

# Summary of findings

- learning disability services in Oxfordshire and Buckinghamshire
- crisis/community mental health teams for adults of working age in Southampton
- child and adolescent mental health in-patient and forensic services

We also reviewed how the trust managed and responded to complaints and how the trust complied with the Duty of Candour regulation. The Duty of Candour regulation requires organisations registered with CQC to be open and transparent and apologise when things go wrong.

We gave the trust several days' notice of the date of the inspection as we could not conduct a meaningful inspection of the issues that were the focus of this

inspection without gathering information from the trust in advance of the site visit and we needed to ensure that members of the senior team were available to meet with us.

We did not provide a rating for any of the core services we inspected or an overall rating for the trust.

## Bluebird house and Leigh House

At the last inspection of the adolescent inpatient and forensic services in October 2014, we found that the trust was in breach of five regulations of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2010: Regulation 9,11,17,18 and 22. At this inspection in January 2016, we followed up on the improvements that we had told the trust to make.

## 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?

On this inspection, we focused on actions we had required the trust make in our previous inspection undertaken in October 2014, report published in February 2015, and actions we had suggested they make. However, we reported on some issues that were outside of these areas when we saw them on inspection. Before the inspection visit, we reviewed information that we held about these services, and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited Leigh House and Bluebird House, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 10 patients who were using the service
- spoke with the managers for each of the wards
- spoke with 27 other staff members, including doctors, nurses, and estates and facilities managers
- interviewed the divisional director with responsibility for these services
- attended and observed four handover meetings and three multidisciplinary meetings
- looked at 12 treatment records of patients
- carried out a specific check of the medication management on both wards
- 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

During the inspection, we spoke with ten young people at Leigh House and Bluebird House. All the young people we spoke with were positive about their experience and

# Summary of findings

felt that staff respected and listened to them. If they raised a concern, they knew that the staff team would act on it. They received support that was appropriate to their needs.

Young people said that the staff were kind and supportive. All the young people we spoke with said they

were involved in identifying their needs and they received enough support. As noted at the previous inspection, the staff in all the teams we visited were committed and enthusiastic about their work with young people to promote their recovery.

## Good practice

At the October 2014 inspection, we found high levels of staff commitment and enthusiasm in Bluebird House,

where young people were involved in all aspects of their care and support. At this inspection in January 2016, we found this was again the case and Leigh House had worked hard to achieve the same high standard.

## Areas for improvement

### Action the provider **MUST** take to improve

#### Action the provider **MUST** take:

- The provider must ensure that it follows the Mental Health Act Code of Practice (chapter 26, paragraph 26.128). This requires that the responsible clinician or duty doctor (or equivalent) undertakes the first medical review of a young person in seclusion within one hour of the commencement of seclusion, if the seclusion was authorised by an approved clinician who is not a doctor or the professional in charge of the ward.

### Action the provider **SHOULD** take to improve

#### Action the provider **SHOULD** take to improve

- The provider should ensure that there are suitable arrangements in place to ensure that all young people are involved in all aspects of planning their care and treatment in Bluebird House.
- The provider should ensure that where rapid tranquilisation is used by intramuscular injection, young people in Bluebird House have their physical health observations monitored on the format within their care files.
- The provider should ensure that persons providing care or treatment to service users have the

qualifications, competence, skills and experience to do so safely. The provider should ensure that they address the high levels of prone restraint and provide staff at Bluebird House with appropriate restraint training as agreed.

- The provider should ensure that suitable arrangements are in place to obtain the consent of patients in relation to the care and treatment provided in Moss and Stewart wards in Bluebird House.
- The provider should ensure that staff in Bluebird House always record the length of seclusion and the time when seclusion has ended.
- The provider should ensure that staff in Bluebird House continue to monitor the use of prone restraint (a type of restraint someone laying with the front of their body on a surface) and there is senior oversight of this.
- The provider should ensure that a medical emergency bag is available on all wards at Bluebird House. We noted the wards were spread out and it would take staff in the region of five minutes to go to Hill ward where the bag was kept, potentially putting young people at risk.

## Southern Health 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
Leigh House	Leigh House
Stewart ward Hill ward Moss ward	Bluebird House

#### 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.

At the October 2014 inspection, we found there was regular use of restraint, but that staff were not following the Code of Practice: Mental Health Act and that the trust did not have a policy and or procedural guidance relating to this. At this inspection in January 2016, we found the Code of Practice was being followed in Leigh House and there were

appropriate policies and procedures in place. In Bluebird House, there were appropriate policies and procedures but the Code of Practice was not being followed. This was because the responsible clinician or duty doctor (or equivalent) was not undertaking a medical review of young people within one hour of the commencement of seclusion when this occurred outside of working hours (Code of Practice, chapter 26, paragraph 26.128).

#### Mental Capacity Act and Deprivation of Liberty Safeguards

The Mental Capacity Act does not apply to young people aged 16 or under. For children under the age of 16, the young person's decision-making ability is governed by Gillick competence. The concept of Gillick competence

# Detailed findings

recognises that some children may have sufficient maturity to make some decisions for themselves. The staff we spoke with were conversant with the principles of Gillick and used this to include the patients where possible in the decision making regarding their care.

# 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

### LeighHouse

#### Safe and clean environment

- The ward was clean and well maintained. The ward layout did not allow staff to observe all parts of the ward but staff managed these areas well with relational security (the knowledge and understanding staff have of a patient and of the environment, and the translation of that information into appropriate responses and care). They knew where young people were and attempted to engage them if they isolated themselves.
- The manager had completed a comprehensive risk assessment in 2015 of all ligature points throughout the ward, including the high care area (HCA) and the anti-ligature room (room 1.027). Following the risk assessment, in October 2015 the trust completed the work identified as necessary. For example, in the HCA bathroom, the mirror had been replaced with special shatterproof material and there was new sanitary ware with sensor taps. There were ligature-proof tracks for both shower curtains and curtains in the living area. The cupboard handles in the drinks bay had been replaced and were anti-ligature. Staff had ensured the lights and room sensors would not hold a person's weight to ensure young people's safety.
- There were still some ligature risks in the HCA, for example, taps in the drinks bay and the window catches in the bathroom. The matron told us that the trust was in the process of ordering these items. These risks were reduced by increased levels of staffing. For example, when young people were in the HCA, staff placed them on one-to-one or two-to-one observations. Young people spoke positively about using time in the HCA for quiet reflection.
- Room 1.027 was designed to be an anti-ligature room for those young people whose initial assessment identified a risk of self-harm. The manager had ensured the room was ligature free with the exception of the window catches. Anti-ligature catches and a new radiator cover had been ordered and this work was scheduled to be completed by the end of February 2016.
- The manager had ensured that the ward complied with Department of Health guidance on same sex accommodation. The ward was divided into male and female sleeping areas. Each area had its own lounge, bathroom and kitchen area. There were separate kitchens and lounges for males and females.
- The clinic room had the necessary equipment to carry out physical health checks on young people. The room was clean and well organised. Staff kept the emergency resuscitation kit in the clinic room and records showed that staff carried out checks to ensure that equipment was present and in suitable condition. For example, staff checked the defibrillator weekly and carried out daily checks of the refrigerator temperature to ensure drugs that needed refrigeration were stored at the correct temperature. The clinic had suitable arrangements for the disposal of clinical waste. There was information on the wall to remind staff of the observation procedure following rapid tranquilisation. Medicines were dispensed from a separate room. This room was very small but was suitably equipped with locking cabinets and was in a quiet area of the ward. The ward manager told us that previously staff had administered medicines from the clinic room. However, the clinic room was on the main corridor of the ward so staff were often interrupted, which contributed to medicines errors. The relocation of the medicine administration to a quiet area of the ward had resulted in more privacy for young people and a reduction in medicines errors.
- The ward did not have a seclusion suite and therefore did not have a room suitable for this purpose according to the Code of Practice Mental Health Act 1983 guidelines. The matron and staff were very clear that the HCA was used for young people who required 'time out' and comprised two bedrooms, a lounge area, two shower rooms and a drinks area. Staff told us that the HCA was not used for seclusion except in extreme cases when the young person became a danger to themselves and others. In those cases the seclusion policy and the Code of Practice was followed. We were shown a policy regarding HCA protocol that outlined the criteria for using the area. Staff told us that if a young person remained in the HCA for more than 48 hours with no

# Are services safe?

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improvement in their behaviour, meaning they were unable to go back onto the ward, then staff informed trust managers who would seek a new and more suitable placement as a matter of urgency.

- The hospital was purpose built and set in its own grounds. It had its own school, a games room, an art room, a sports hall and a fitness studio. There was also a facility for the accommodation of parents and carers. The ward included bedrooms, a relaxation area, and a seclusion room. All areas including the wards were well maintained and the corridors were clear and clutter free. Young people told us that standards of cleanliness were usually good. Staff conducted regular audits of infection control and prevention, and staff hand hygiene to ensure that young people and staff were protected against the risks of infection. The manager monitored the housekeeping staff's adherence to the cleaning schedule to ensure the ward was both hygienic and clean.
- The patient-led assessment of the care environment (PLACE) survey data for Leigh House confirmed that the ward was well maintained. For example, compliance with cleanliness was 100%, privacy, dignity and well being for Leigh House was 92%. Condition, appearance and maintenance was 93%.

## Safe staffing

- The trust had carried out a review of nurse staffing. This set staffing levels on the ward. We reviewed the staff rotas for three months prior to our inspection and saw that staffing levels were in line with the levels and skill mix determined by the trust as safe. For example, the trust assessed that two qualified nurses were to be on duty at all times and records confirmed this was the case. The trust informed us that the current staffing establishments were 21.6 WTE qualified nurses, 16 were in post, three have been recruited with pending start dates. The matron had incorporated 1.4 WTE over establishment to ensure there was sufficient cover for staff sickness or absence. There were currently 2.7 WTE vacancies of qualified nurses.
- There were five health care support workers during the day, and two at night. At weekends, there were three health care support workers during the day, and two at night. During weekdays, the acting ward manager and the modern matron worked office hours. The

establishment for healthcare support workers was 18.7 WTE, there were 0.8 vacancies and one post has just been recruited to. Patients stated there were enough healthcare assistants to enable them to complete activities.

- The number of shifts filled by bank or agency staff to cover sickness, absence or vacancies over three months was 163, which was about 12% of the total. The number of shifts that the trust had not filled by bank or agency staff, because of sickness, absence or vacancies over three months, was low at 25. The modern matron informed us that shifts were regularly filled by senior staff, such as the modern matron to reduce agency/bank use and ensure consistency for the young people.
- Sickness rates were low. Records showed the rate was 2.3%. Staff members in the focus group said the ward was a positive place to work and that impacted upon sickness levels.
- Staff turnover in the previous 12 month period was 25%. The matron informed us that at the beginning of the year there had been a large staff turnover that had stabilised towards the latter end of the year. No qualified nurses have left since January 2015 but three health care assistants had left to take up mental health nurse training, one left to take up occupational therapist training and four left to take up posts outside of the trust.
- The ward manager was able to request additional staff should the need arise, for example if there were specific activities taking place. Young people spoken with confirmed that activities were rarely cancelled due to lack of staff.
- The ward had an out of hours on call rota, this included the modern matron, the ward manager and Band six nurses. Staff stated they found it useful to know who to call on in an emergency.
- The matron said they followed the good rostering guide and safer staffing policy, and senior staff met regularly to ensure they met safe staffing levels on a daily, weekly, monthly and quarterly basis.
- Staff ratio was one staff member to three young people. This was set against the QNIC standards (a network that aims to demonstrate and improve the quality of



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inpatient child and adolescent psychiatric in-patient care). Three young people spoken with stated there was sufficient staff on duty even at weekends and they could easily find staff if they needed them to assist them.

- The staff numbers meant that there were enough staff to initiate a physical intervention while still allowing staffing presence in ward areas for the other patients.
- Staff received appropriate training relevant to their role, including safeguarding children and adults, life support techniques and fire safety. Records showed that most staff were up-to-date with statutory and mandatory training. The manager had access to the electronic staff records to oversee their progress in completing their training. The training helped to ensure staff were able to deliver care to young people safely.

## Assessing and managing risks to patients and staff

- There were three occasions in the last year where the multidisciplinary team had assessed that seclusion would be in the young person's best interests. In all three cases seclusion records confirmed the trust's policy on seclusion was followed.
- Staff were skilled in de-escalation techniques and able to describe how they would only use restraint as a last resort. Staff demonstrated they knew and followed the restraint procedure. Staff involved in 'hands-on' restraint situation were trained in proactively reducing incidents for safer services. The trust had trained support staff, such as administration staff and cleaners, in breakaway techniques. We saw evidence of staff receiving this training in the training records. Staff showed us their policy on the management of violence and aggression and were able to explain how incidents of violence/aggression/restraint were recorded. Staff ensured that they completed risk assessments for each young person on admission and included any special conditions and factors to be considered in the event of a restraint situation being needed. We saw evidence of this in patient records. Staff told us that following an episode of restraint, they asked the young person to complete a patient feedback form. We were told that, sometimes, young people refused to do this. However we saw evidence that debriefs happened in five patient files. There had been no episodes of prone restraint.
- We looked at the electronic care records of four young people. For each young person, staff had a completed

risk summary, which was linked to their care plans. Staff had completed risk assessments following incidents. One young person's risk assessment clearly set out the link between risk and observation level. As their risk increased so did their observations and, when risk decreased, staff then reduced observations. In another young person's records, it showed that as their risk had increased, staff had increased their observation and had explained the reasons to the young person.

- The staff team ensured informal patients could leave at will. Information in five care records and discussion with three young people confirmed this was the case.
- The trust had policies and procedures in relation to the use of observation and searching patients that were known to staff.
- Staff used NICE guidance in relation to the use of rapid tranquillisation. In the five electronic patient records reviewed, each young person had a detailed rapid tranquilisation care plan. The plan explained what medication staff would offer initially and how and where staff would carry out rapid tranquilisation. Each young person's care plan contained information about their preferred de-escalation and distraction techniques.
- We looked at the records on one young person who had recently received rapid tranquilisation. Staff had carried this out in accordance with trust policies and procedures. Staff had access to a flowchart on safe administration of intra-muscular rapid tranquilisation. Following the administration to the young person staff had carried out the correct level and recording of observations.
- Seclusion was used appropriately and followed the trust's guidance on recording incidents and the seclusion pathway. We looked in detail at the three episodes of seclusion that took place in the last year and saw the correct paperwork had been completed in line with trust policy and seclusion recording protocol. We asked all staff present at the inspection, in what circumstances they would consider that time spent in the HCA would need to be considered as seclusion and staff told us in cases where the young person was a danger to themselves or others and it was felt necessary in the best interest of the child. The ward followed the Code of Practice: Mental Health Act 1983 – chapter 26.104. This states that if a patient is confined in any way



# Are services safe?

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that meets the definition above, if they have agreed to or requested such confinement, then they have been secluded. The use of any local or alternative terms (such as 'therapeutic isolation') or the conditions of the immediate environment do not change the fact that the patient has been secluded. It is essential that they are afforded the procedural safeguards of the Code.

- All staff spoken with knew that the modern matron was the child protection lead. Staff we spoke with understood their responsibilities to raise safeguarding concerns. They had access to written safeguarding processes and these were up to date and in line with current guidance, for example, The Children Act. The matron had good links with the safeguarding team and actively sought advice from them. Training records confirmed 71% of staff were trained in safeguarding children level 3.
- Medications were managed safely. Medicines were dispensed from a separate room and all medicine cupboards and refrigerators were tidy and locked. The room was very small but was suitably equipped with locking cabinets and was in a quiet area of the ward. A qualified nurse kept the keys. Staff monitored fridge temperatures and these were within the guidelines for maintaining the effectiveness of medicines.
- The matron told us that previously staff had administered medicines from the clinic room. However, the clinic room was on the main corridor of the ward and staff were often interrupted, which contributed to medicines errors. The relocation of the medicine administration to a quiet area of the ward had resulted in more privacy for young people and a reduction in medicines errors.

## Track record on safety

- There were 847 incidents relating to Leigh House in the twelve months from 05 January 2015 to 14 January 2016. The manager said in the month of April 2015 there were more incidents than average, as there were two very challenging young people at that time. Young people spoken with confirmed that this period was very unsettled. It became calmer after the two young people had left. The data provided by the trust showed us there

were 115 incidents in April 2015 and then 48 in May 2015 and 49 in June 2015. The young people told us they felt safe and trusted the staff to deal with any incident appropriately.

## Reporting incidents and learning from when things go wrong

- Staff reported all incidents on an electronic system called Ulysses. All staff we spoke with knew how to report incidents on the system. The four incident reports seen contained an appropriate level of detail about both the event and any injuries sustained by staff or young people. All incidents were reviewed by the matron.
- The manager ensured that staff were open and transparent and explained to patients if things went wrong. The staff team recorded learning from the findings of previous incident investigations in their staff meeting minutes. Staff spoken with confirmed they knew about improvements that had been made to improve practice.
- The matron attended serious incident meeting (SIRI) meeting about serious incidents trust wide and this information was disseminated through the nurses meetings and integrated governance. For example, meeting minutes confirmed information about the care of young people with epilepsy was shared.
- All seven staff spoken with told us they had the opportunity to have a formal de-brief after a serious incident and that they could access additional counselling support from the trust if needed. Three young people told us how they were each offered a debrief from the staff when they had witnessed a young person being restrained. They said they found it useful.

## Bluebird House

### Safe and clean environment

- In Bluebird House, the wards layout did not allow staff to observe all parts of each ward. For example, staff could not easily see young people in the area between the communal area and the bedrooms. However, staff positioned themselves in these areas whilst young people were in their rooms to ensure their safety.
- All the three wards had comprehensive ligature risk assessments which identified areas of concern with a

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clear plan to address or mitigate the risk. The wards complied with guidance on same-sex accommodation. In Bluebird House, two wards were same gender and the third admitted both males and females, with separate corridors for separate same gender sleeping and bathing. All bedrooms had an ensuite, with a toilet and shower for each young person.

- All wards were clean and had well maintained soft furnishings. Each ward had been personalised and decorated by the young people. One ward was painted with scenes from Frozen. One young person told us they found the ward comfortable. The PLACE data survey score for cleanliness was high at 98%, privacy, dignity and well being for Bluebird House was 84% and condition, appearance and maintenance was 80%
- Staff adhered to infection control principles. They conducted regular audits of infection control and prevention. Staff followed hand hygiene procedures to ensure that people who use the service and staff were protected against the risks of infection.
- The communal area was well maintained and clean. Cleaning records were up-to-date and demonstrated that the environment was regularly cleaned. Environmental risk assessments were undertaken regularly. Cleaning records and environmental risk assessments were up to date and monitored by the manager.
- Clinic rooms in Bluebird House were clean and well ordered. There was a well-equipped emergency grab bag on Hill ward in a clearly marked location with oxygen and a defibrillator. Equipment was regularly serviced and maintained and in date. The other two wards did not have an emergency bag. This meant that staff had to go to Hill Ward to collect it or call Hill ward staff to bring it. Nursing staff said there had been discussion on having a bag on each ward, but they were not aware if this was going to happen. We noted the wards were spread out and it would take staff in the region of five minutes to go to Hill ward, potentially putting young people at risk.
- There were two seclusion rooms at Bluebird house and both were fully compliant with the Code of Practice: Mental Health Act 1983: recommendations. Both rooms had outward opening doors, clear sight of a clock, natural daylight and two-way communication systems.

There was clear observation via CCTV monitors and observation panels. They also had bathroom facilities and temperature controls to ensure the young people were comfortable.

- The seclusion areas could not be accessed from the ward; therefore, staff brought the young people from the ward through an airlock door and along the main unit corridor to this area. The trust recognised that the seclusion area required improvements. The trust told us that a request “has been submitted for consideration to upgrade the seclusion suites and make three suites instead of two. Each of the three seclusion suites would then be directly accessed from one of the three wards allowing improved dignity and privacy during these incidents. The bid will need to be considered against other priority areas for the financial year”.
- Each ward also has a de-escalation suite and staff were very clear that the moment a young person was stopped from leaving the de-escalation suite then it became a seclusion situation and trust policy and procedure would be followed. The trust had updated the seclusion policy to comply with the Code of Practice in relation to recording procedures. Staff we spoke with were able to explain the policy changes to us and showed us the updated recording paperwork.

## Safe Staffing

- Bluebird House staff told us that funding across the three wards allowed for 49.1 WTE health care support workers and 49.5 WTE qualified nurses, there were 1.1 WTE health care support worker vacancies and 17.5 WTE qualified nurse vacancies. Staff told us it was particularly difficult to recruit band five registered mental health nurses. To mitigate this, managers from all three wards met daily to ensure all wards had sufficient staff. Managers stated they found this useful.
- The number of shifts filled by agency staff to cover sickness, absences or vacancies in the last three months was 612. However, staff ensured the same agency staff were used to ensure consistency for the young people.
- Staff sickness was 7.0% for the previous year. This was three times higher than the sickness rate at Leigh House. The staff turnover rate was 24.9% which was the same as that of Leigh House.

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- There was a clear system in place if staff were unable to cover shifts via the day's establishment they would put a request out to their own staff. If they were not able to supply bank staff managers would request authorisation for agency staff to be booked. Ward managers completed an incident record if staffing was low. The trust monitored this and it was reported in the monthly safer staffing report to the board.
- Ward managers told us they were able to block book NHSP staff (provider of bank staff to the NHS) but not agency staff. We reviewed all three ward rosters over the past nine months. There had been high usage of bank or agency workers. At times there had been five such workers on a single shift. Ward managers stated that their aim was to ensure that agency staff were with experienced staff at all time who were familiar with the ward.
- There was an out of hour's roster consisting of the consultant and senior nurse. We were concerned about the lack availability of junior doctors at night. Further evidence is available in the records of seclusion later in the report. Nursing staff were aware to inform the lead consultant psychiatrist in the unit if junior doctors did not attend. However, they did not regularly complete incident forms. The lead consultant raised the issue with the deanery that coordinated junior doctors training and on call. The issue was not on the risk register, the unit did not have its own risk register. Senior clinical staff did not know if the issue about junior doctors was on the divisional risk register. Staff within the service were not able to tell us what was on the divisional risk register in relation to their service.
- There were restrictions in place in relation to what items could be brought onto the ward. For example, there was a list of items for staff, visitors and patients, like keys or phones, which could not be brought onto the ward as they posed a risk to the young people.
- All young people going on section 17 leave from the unit had a mental state examination completed before they left by nursing staff and recorded in the notes. This applied to both escorted and unescorted leave. It clearly assessed the risk to the young person and others prior to access to the community.
- There were clear policies and procedures for the use of observation, to minimise risk from ligature points and searching patients.
- At the October 2014 inspection we noted that the service used a high proportion of prone (face down) restraint with the young people. At that time, there were not suitable arrangements in place to manage the restraint of young people and the records relating to restraint did not demonstrate that this was always managed appropriately. At this inspection in January 2016, new systems were in place to monitor restraints.
- Information provided by the trust showed 989 incidents of restraint involving 29 different young people at Bluebird House between 01 February 2015 and 25 February 2016. 477 of these incidents were prone restraint. The staff told us that when this form of restraint was used, they turned the young person's head to the side to reduce risks to them. We looked at 10 restraint records and found eight used prone restraint. On two occasions this was after the use of an arm restraint. The staff spoken with, young people and matron confirmed that young people's head were turned to the side during these restraints.
- A training request was submitted to the trust for 'supine only' restraint training for staff to reduce the number of prone restraints, in September 2015. The trust advised that supine only restraint would be rolled out as training to Bluebird house in April 2016. During this inspection, the trust advised that training would be rolled out to staff from April 2016. The trust has since told us that it is developing a programme "which will see staff trained in a variety of different restraint techniques including

## Assessing and managing risk to patients and staff

- At the October 2014 inspection we found that there were clear risk assessments detailing the support that young people needed to minimise risk, with details of any potential risks or triggers to cause them anxiety or stress. However, we found at that time that staff did not always update them following an incident to ensure that they provided the necessary support. At this inspection in January 2016, we found that all seven of the records reviewed at Bluebird House had comprehensive up to date risk assessments. There was a clear record of reviews of all risk assessments regularly in ward round or following an incident.
- A training request was submitted to the trust for 'supine only' restraint training for staff to reduce the number of prone restraints, in September 2015. The trust advised that supine only restraint would be rolled out as training to Bluebird house in April 2016. During this inspection, the trust advised that training would be rolled out to staff from April 2016. The trust has since told us that it is developing a programme "which will see staff trained in a variety of different restraint techniques including

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supine with the main focus being on reducing the frequency of restraint and its duration when used” and as such the training package will not be implemented in April 2016.

- Staff working at Bluebird House could explain the process of physical health monitoring following the use of rapid tranquilisation. This included the monitoring of physical health by using track and trigger charts which showed nurse when observations such as BP, pulse and respiration were not in normal ranges. The unit used the “physiological observation chart adolescent track and trigger tool” which was appropriate for the age of the young people. However, on the last three occasions where rapid tranquilisation was used by intramuscular injection, only one young person had their physical health observations monitored on the tool. Flumazenil was available on Hill ward with clear instructions that it could only be given by a doctor. Staff were aware to call 999 if no doctor was available and a young person was showing an adverse reaction to rapid tranquilisation.
- The seclusion paperwork in relation to medical review was not always completed appropriately. We reviewed the seclusion audit for Hill ward from 09 November 2015 to 04 January 2016. Of the 17 seclusion records, five had not been attended by a doctor in the time period set out in the Mental Health Act Code of Practice. This did not meet chapter 26, paragraph 26.128 of the Code which states that the first medical review should, if seclusion was authorised either by an approved clinician who is not a doctor or the professional in charge of the ward, be undertaken by the responsible clinician or duty doctor (or equivalent) within one hour of the commencement of seclusion.
- This issue arose out of hours when the responsible clinician was not available. We cross-referenced paper copies of seclusion records with those held on the electronic care record system for six incidents of seclusion across all three wards where the on call doctor had failed to attend in the time set out in the guidelines of both the trust’s policy and within the Code of Practice: Mental Health Act 1983. We saw evidence on the electronic care record system that staff followed trust guidelines and contacted doctors at the start of seclusion. However, evidence on the electronic care record system confirmed that, despite several phone calls to on call doctors, they were unable to attend due to being needed elsewhere in the trust. For example, one record showed that doctors had not seen a patient who was secluded at 22:25 within the time frame. The patient was seen the following day, despite the seclusion ending at 00:11. The electronic care record system records stated that the doctor was busy admitting patients elsewhere within the trust. The non-attendance of doctors meant that the seclusion paperwork was not fully completed in line with the Code of Practice.
- Staff members used different recording systems in the seven seclusion records we reviewed. The matron told us the paper work used was inconsistent because they used both the previous paperwork and the recently updated paperwork from the managing violence and aggression policy rolled out in November 2015. The content of the records was comprehensive apart from, in four of the seven records seen, staff did not include the length of seclusion or times it had finished in line with Code of Practice.
- The ward had its own social worker who was the safeguarding lead. Training records confirmed that 98% staff had been trained in level 3 safeguarding children. All the staff we spoke with knew how to recognise a safeguarding concern. Staff were aware of the trust’s safeguarding policy and could name the safeguarding lead. They knew who to inform if they had safeguarding concerns.
- There were good systems for managing medicines. Medicines were stored securely. Staff understood waste management procedures and medicine administration records were checked routinely for any omissions or errors.

## Track record on safety

- Between 03 January 2015 to 14 January 2016 inclusive, there were 1386 reported incidents in Bluebird House, (the medium secure facility). There were 468 incidents in Hill ward. In the period November 2014 to October 2015 there were 1,281 incidents. The average for both periods was about 106 per month. In September 2015 the number of incidents was higher than average at 113. The matron told us they had had new admissions, which often led to an unsettled period followed by a period of stabilisation when the young person settled in. We saw there were 84 incidents in October 2015.

# Are services safe?

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## Reporting incidents and learning from when things go wrong

- Staff we spoke with on all the CAMHS wards knew how to recognise and report incidents on the trust's electronic incident recording system. The ward manager reviewed incidents. We saw six incident forms. We saw that the staff did not consistently complete incidents forms in relation to the availability of out of hour's junior doctors promptly.
- The matron ensured that staff were open and transparent and explained to patients if things went wrong.
- In Bluebird House one of the consultant psychiatrists chaired a monthly "learning from incidents" meeting. There was discussion of incidents and complaints and action plans were created and reviewed. It created a clear process to show that the action plan mitigated the risk. Staff felt confident that the meeting ensured learning and were pleased that other specialist services within the trust were using the template of the meeting, which they felt showed its effectiveness.
- In March 2015, a staff member was assaulted with an item of cutlery. In March 2015 a cutlery protocol was put in place and all staff signed the document to show that they had read and understood it. There was also a review of the location of corridor locks because, in the investigation, the staff team identified these locks had been a factor in the incident. Staff members in all wards told us about the learning following the recent incident where a staff member had been injured in the face new guidelines had been put in place to prevent a reoccurrence. All staff spoken to in the focus groups knew about the incident and could describe the subsequent learning.
- Staff from all three wards confirmed that they were given the opportunity to debrief after a serious incident.



# Are services effective?

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

### Leigh House

#### Assessment of needs and planning of care

- At the October 2014 inspection, we found that the young people at Leigh House were not encouraged to be involved in the care planning, decision making or reviews about their care. They also did not attend ward rounds. At this inspection in January 2016 we looked at four electronic patient records and four paper copies of the newly installed collaborative care plans, and saw evidence that young people were now involved in care planning and attended ward rounds.
- The staff team ensured that care plans covered both physical and psychological needs of young people. Paper copies had been signed by young people to confirm they had been involved in the development of these plans. Electronic progress notes showed that staff regularly discussed young people's care with them and where appropriate with their parents or carers.
- Records for young people with an eating disorder contained clear information about their preferences. For example, staff recorded which foods each young person would not eat. Care plans contained information about how young people preferred to be supported when they were distressed. For example, staff had identified which activities were helpful in distracting and calming each young person. We saw that discussions and negotiations about individual care were recorded. For example, staff discussed the increase or decrease of observations, with reasons with young people. At the October 2014 inspection patients felt the service was organised more around patients with an eating disorder (ED). The matron said the service had a disproportional number of young people with ED but they had made efforts to balance these numbers. For example, in August 2015, the number of young people who used the service with ED was 53% and in December 2015, the number was 33%. The matron said all young people now have the same health checks and nutrition care plans. At the October 2014 inspection, young people with ED had more health checks than other young people at the house and this caused some concern to the young people at the time.
- In all five electronic patient records reviewed, each young person had a detailed rapid tranquilisation care plan. The plan explained what medication staff would offer initially and how and where staff would carry out rapid tranquilisation. Each young person's care plan contained information about their preferred de-escalation and distraction techniques.
- We looked at the records of one young person who had recently received rapid tranquilisation. Staff had carried this out in accordance with trust policies and procedures. Staff had access to a flowchart on safe administration of intra-muscular rapid tranquilisation. Following the administration to the young person staff had carried out the correct level and recording of observations.
- All five electronic care records we reviewed recorded that the staff team had conducted a health check for the young person. Each young person's care record contained information about the frequency of any health checks needed. Some young people needed to have their blood pressure and pulse checked at least daily, whilst others had weekly checks.
- Young people's electronic records contained the results of any blood tests. The unit followed NICE guidance regarding the frequency of blood tests for young people with psychosis. Staff weighed all young people at least weekly and calculated any change in their weight. Young people's physical health was discussed at the morning handover which was attended by a range of professionals within the multidisciplinary team. Staff used this information to determine any changes to young people's care plans. For example, they might decrease the level of observation following weight gain or reduce exercise following weight loss for young people on the eating disorder programme.
- Staff explained that each young person had a nutritional care plan because young people on anti-psychotic medication needed support to avoid excessive weight gain whilst young people with an eating disorder needed to gain weight. They had developed a bi-monthly positive lifestyle group which the dietitian attended. The purpose of the group was to support all the young people to develop healthy lifestyle choices. The group had developed a leaflet on healthy eating for young people and their families.

# Are services effective?

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## Best practice in treatment and care

- NICE guidance was followed prescribing medication. We saw examples of this in patients' records. Patients could access psychological therapies as part of their treatment and psychologists were part of the ward team.
- The staff team ensured records of health observations were always completed. The lead doctor for physical healthcare at Leigh House confirmed that they checked observation charts every morning in the doctors' meeting. The lead doctor for physical health care told us that they regularly reviewed the need for physical observations.
- The ward staff assessed patients using the Health of the Nation Outcome Scales that covered 12 health and social domains. They also used the children's global assessment scale; which is a numeric scale (one through 100) used by mental health clinicians to rate the general functioning of children under the age of 18 at the point of the admission and discharge of young people). There was in addition the use of Junior MARSIPAN (Management of very sick patients under 18 years old with anorexia nervosa) for work with young people with eating disorders. This enabled the clinicians to build up a picture over time of their patients' responses to interventions.
- The wards also used a number of measures to monitor the effectiveness of the service provided. They conducted a range of audits on a weekly or monthly basis on incidents, staffing, young people's experience, complaints, and safeguarding.

## Skilled staff to deliver care

- Leigh House had a dedicated practice development nurse to ensure that staff attended mandatory training, and to provide specialist training based on needs. Staff received appropriate training, supervision and professional development. Staff told us they had undertaken training relevant to their role, including safeguarding children and adults, fire safety, life support techniques and the use of physical interventions. Records showed that most staff were up-to-date with statutory and mandatory training.
- At the time of the last inspection, the trust had recruited a number of new staff, including a large number of newly qualified staff. The ward team included psychiatrists, registered nurses, healthcare support

workers, psychologists, occupational therapists and administration staff. There was also input from a dietician. A social worker was being recruited to assist the matron with their child protection role.

- All staff attended a two-day induction that included an introduction to the care certificate training in social care. Staff were required to complete the competencies during the probationary period. Staff also received a two-day orientation period on the ward that included familiarisation with policy and procedure.
- The matron ensured that staff received clinical and managerial supervision monthly Appraisals were completed annually during the months of May, June, July. Staff received one-to-one supervision at four to six weekly intervals. They stated appraisal goals were monitored via this process. Staff received yearly appraisals. In the three documents reviewed, there was no formal transfer of goals from the appraisal document to the supervision document for monitoring. Staff confirmed this information was not recorded. The trust did not employ the domestic staff and therefore they did not receive one to one supervision. However, staff informed us that the estates manager liaised with the contractor to ensure service delivery was regularly monitored.
- There were regular team meetings and staff felt well supported by their manager and colleagues on the ward. All staff spoken with said they had a strong sense of team and they worked well together.

## Multidisciplinary and inter agency team work

- A multidisciplinary meeting took place four times a week, those attending included a nurse, psychologist, occupational therapist, a staff grade doctor, consultant, and sometimes a family therapist. The care records showed evidence of multi disciplinary working across the onsite multidisciplinary team. Young people did not attend multidisciplinary meetings, however, they were able to contribute through the completion of a feedback form and attending ward rounds.

## Adherence to the MHA and MHA Code of practice.

- Records confirmed that staff had received training on the Mental Health Act (MHA) and the Code of Practice:

# Are services effective?

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Mental Health Act 1983. The use of the MHA was good in the ward. The documentation we reviewed in detained patients' files was compliant with the Act and the Code of Practice.

- The matron ensured that staff assessed and recorded mental capacity and consent for young people on admission to Leigh House. It was also reviewed and documented on the electronic care record system after each ward round on the ward round template.
- Information on the rights of young people who were detained was displayed in wards. Independent advocacy services were available to support young people if required. Staff were aware of the need to explain young people's rights to them to ensure they understood their legal position and rights in respect of the MHA.
- Staff knew how to contact the MHA office for advice when needed and said that regular audits were carried out throughout the year to check the MHA was being applied correctly.

## Good practice in applying the MCA

- The Mental Capacity Act does not apply to young people aged 16 or under. 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. At the October 2014 inspection, we found the staff were not aware of having training in relation to the use of the Mental Capacity Act 2005 (MCA) with young people, or of the Gillick Competencies. There was a lack of understanding of staff responsibilities in relation to ensuring the assessment of capacity and consent. Where assessments of capacity had taken place, these were not decision-specific to comply with the MCA. At this inspection, January 2016, the staff we spoke with in both Leigh House and Bluebird House knew about the principles of Gillick and used this to include the patients where possible in the decision making regarding their care.
- Training about MCA was included in the safeguarding training. They had in the region of 90% compliance rate across the two locations.

## Bluebird House

## Assessment of needs and planning of care

- Admissions to Bluebird House were generally planned. This allowed staff to undertake a comprehensive assessment of the young person's needs before they were admitted. In the five care records we reviewed, more detailed assessments that covered a wide range of needs were completed once the young person was in the service.
- The matron had ensured physical healthcare of the young people was a high priority. All young people received a full physical health examination on admission. There was regular monitoring following this by a track and trigger tool that was completed weekly by nursing staff and blood tests were completed regularly. The physical health needs of young people was a standing item on the weekly ward round template and recorded the young person's electronic record. The unit had arranged for a dentist to visit the unit on a regular basis and they had a fully fitted dentist surgery. Despite repeated efforts, local GP surgeries had been unwilling to consider registering the young people on the unit and providing primary care. All physical healthcare was provided by the unit's medical staff.
- In Bluebird House, care plans on Hill ward and Moss ward were generally comprehensive; however, the patient's voice was not always presented as clearly on Stewart ward. Nursing care plans did have the young person's voice and views in them, however care plans put in by other professional groups did not. The care plans were detailed and clinically robust but were not written in an accessible way for young people. Some young people had very good "portfolio" care plans kept on the ward. These used a template designed by young people using visual aids. Unfortunately, these were not consistently used and could not be scanned and saved on to the electronic record system the electronic care record system. However, care plans on Stewart ward were very good. They were up to date holistic and recovery orientated with the patients voice used throughout and presented in a way that young people could easily follow.
- Records were stored securely on an electronic records system and staff were confident in its use. However, there was an issue in scanning paper records onto the system, meaning that staff kept separate files for young people.



# Are services effective?

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## Best practice in treatment and care

- NICE guidance was followed prescribing medication. We saw examples of this in patients' records. Young people could access psychological therapies as part of their treatment and psychologists were part of the team to provide treatment for the young people.
- The staff at Bluebird House were proactive in positive risk taking. For example, there were detailed plans and assessments to enable a young person who was a risk to themselves to go swimming. This included occupational therapy assessments, details of how staff were to support throughout the trip and assessments of mental state prior to going each time.
- The staff team used the Health of the Nation Outcome Scales for Children and Adolescent Mental health, the Paddington Complexity Scale and the Children's Global Assessment Scale to gauge young people's level of functioning and the effectiveness of the treatment.

## Skilled staff to deliver care

- Staff received appropriate training, supervision and professional development. For example, the training matrix for Stewart and Moss ward showed staff have completed training in assessment and positive risk taking, life support techniques, the Mental Health Act (MHA) and proactively reducing incidents for safer services. Records showed that most staff were up-to-date with statutory and mandatory training.
- All staff attended a induction that included an introduction to the care certificate training in social care. Staff were required to complete the competencies during the probationary period.
- The matron ensured staff received one-to-one supervision at four to six weekly intervals. For example, the ward manager on Stewart ward stated 73% of staff had received supervision in December 2015. They stated appraisal goals were monitored via this process. Staff received yearly appraisals.

- There were regular team meetings and staff felt well supported by their manager and colleagues on the ward. The ward managers said staff morale was generally good on the wards.

## Multidisciplinary and inter-agency team work

- The care records showed evidence of multidisciplinary working across the onsite multidisciplinary team. There was onsite social worker who enabled positive links with social services, within safeguarding, tribunals, manager's hearings and discharge planning.

## Adherence to the MHA and the MHA Code of Practice

- In Bluebird House capacity and consent was assessed and recorded for all young people. On Hill ward, there was a discussion of whether a young person still had this at every ward round. There were also detailed individual assessments of young people by the psychiatrist. On Moss and Stewart wards, although mental capacity and consent were assessed, they were recorded in the narrative of the notes normally around the point of medication changes. This was not as clear and did not explicitly cover consent to other treatments such as psychological interventions.

## Good practice in applying the MCA

- The Mental Capacity Act does not apply to young people aged 16 or under. 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. The staff we spoke with at Bluebird House knew about the principles of Gillick and used these to include the patients where possible indecision making about their care.

# 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

- At the October 2014 inspection, we found that the staff teams at both Leigh House and Bluebird House demonstrated an good attitude and approach towards the young people. All the staff were highly motivated and committed to working with the complex needs of the young people. At this inspection in January 2016, we found this remained the case. All young people spoken with in both Leigh House and Bluebird House were complimentary about the staff team. In Leigh House, one young person spoke of the readiness of the staff to listen to them. In Bluebird House, one young person said there was always someone to speak to and commented positively on the high levels of support they received from the team.

### The involvement of people in the care they receive

#### Leigh House

- At the October 2014 inspection, the young people told us that they did not feel particularly involved in identifying their needs and planning their care. At this inspection in January 2016, Leigh House had worked hard to ensure young people were included in their care. As previously stated a dedicated staff member had revised all the care records to include a collaborative care record to ensure there was clear evidence of their input. Three young people spoke positively about this document and said it focused them on their expectations and the type of care they wished to receive.
- Young people at Leigh House were encouraged to give feedback and contribute to the running of the unit. Staff held a daily community meeting and a monthly 'voices for choices' meeting. Young people could raise issues or give feedback at either meeting. For example, the young people asked for beanbags and the staff team investigated soft chairs that would also not pose any risk to the young people. They found suitable soft chairs which were on order at the time of the inspection. One young person commented that staff were responsive to meet their requests.
- Managers discussed the minutes of the 'voices for choices' meeting at their integrated governance

meeting. Minutes of meetings showed that there was clear communication between the voices for choices group and the integrated governance group. For example, during the implementation of the ward round forms, both groups discussed and reviewed how they were working regularly.

- We looked at the minutes for both meetings and saw that young people had been involved in discussion about the new advocacy service. Commissioners in Hampshire were considering the re-tender of advocacy services, and young people said they wanted to retain their current advocate. Managers discussed this at the integrated governance meeting. Consequently, the occupational therapy manager emailed Hampshire council to pass on the young peoples' views on the choice of advocate.
- The Leigh House advocate attended the weekly community meetings and spent time with the young people following this. Information posters about advocacy were displayed on the unit and pamphlets were available within the patients welcome packs.
- One member of the nursing staff had developed a form to improve the inclusion of the young person's views in clinical meetings. Young people discussed the form in the 'voices for choices' meeting. Young people also requested feedback from the clinical meeting. Staff had discussed this in the integrated governance meeting. Following this, the form was amended and incorporated suggestions made by young people at the meeting.

#### Bluebird House

- In Bluebird House, the matron said the involvement of the young people was a work in progress. There were weekly community meetings and an advocate visited each Thursday. In February 2016, they were relaunching the service user forum, and they used young people feedback questionnaires after discharge although there was no analysis of the contact for 2015 due to the information being sent to another site.
- Five of the seven young people spoken with said they felt involved in their care. Two stated they didn't find the community meetings helpful as they didn't like attending large meetings. When asked of changes as result young people's involvement the matron told us they had asked for a fish tank but this was risk assessed as being too hazardous so, as a compromise, a bubble

# Are services caring?

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

lamp with paper fish was purchased. Young people had also asked for more activities for their families when they visited, as a result a large pool table was purchased. All young people spoken with liked the new table and used it frequently.

# Are services responsive to people's needs?

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

## Our findings

We did not fully inspect this domain because we rated it as good at the October 2014 inspection.

### Access and discharge

- At the October 2014 inspection there was evidence that discharge planning did not routinely happen as part of the admission of young people to the service, which contributed to the smooth discharge of some young people. There was no trust transition policy to support young people transitioning into adult services. There was also evidence that there were no clear care pathways for young people, though there was a good success rate in moving young people on to less supportive services. At this inspection in January 2016 we found this had improved in both Leigh House and Bluebird house. There was clear evidence in all files reviewed of discharge planning and a transitional policy was in place. The social worker at Bluebird house spoke of their frustrations about finding suitable placements.

### Listening to and learning from concerns and complaints

#### Leigh House

- All three young people spoken with said they knew how to make a complaint. There was information on display to advise people how to make a complaint and contact outside bodies, such as the Care Quality Commission and advocacy services.
- Staff responded to complaints by young people or their families. For example, the 'voices for choices' (a group for young people) board in the corridor showed that when young people complained about being too hot to sleep that ward staff purchased cooler duvets. The ward manager kept a folder of informal complaints and concerns. The last informal complaint, which was the only one for the last 12 months, had been in 16 January 2016. The ward manager had responded and offered an explanation and reassurance to a concerned parent. We saw details of a formal complaint where the service manager had involved an independent investigation. The patients and their family had been informed of the outcome and an apology made for parts of the complaint that were upheld.

#### Bluebird House

- At Bluebird House there had been five complaints in the previous year. All were investigated appropriately by the matron.

# Are services well-led?

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

We did not fully inspect this domain because we rated it as good at the October 2014 inspection.

- Since our last inspection, the trust had introduced new performance management software to help ward managers monitor key performance indicators. The trust was in the process of fully training the appropriate staff to use the software. Board meeting minutes showed a range of quality and safety key performance indicators were reported at divisional level and to the board in the integrated performance report.
- While there were a few areas for improvement, both managers in Leigh House and Bluebird House had access to systems of governance that enabled them to monitor and manage the wards and provide

information to senior staff in the trust about compliance with the requirements of the last report. For example, in Leigh House the manager had produced a document for staff showing how they were meeting each requirement and any outstanding actions. Staff members told us they found this useful and kept them focused. In Bluebird House the manager had made improvements like introducing ward managers meetings to distribute staff across all the wards, opened up the beverage areas for young people and made changes to the layout of the wards so they were more open plan. In both Leigh House and Bluebird House staff and young people were complimentary about the managers and spoke positively about the impact they had made on each ward.

- Staff morale was good, and staff felt supported and that they would be listened to if they raised concerns.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	<p>Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect</p> <p><b>In Bluebird House medical staff were not able to attend young people's medical reviews, within one hour of the commencement of seclusion, as they had other commitments.</b></p> <p>This is a breach of Regulation 12 (2) (a) (b)</p> <p>Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)</p>