Good

Birmingham Children's Hospital NHS Foundation Trust

Child and adolescent mental health wards

Quality Report

60 Queensbridge Rd,
Birmingham B13 8QE
Tel:0121 333 9999
Website: www.bch.nhs.uk/

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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)
RQ330	Parkview Clinic	Ashfield Unit	B13 8QE
RQ330	Parkview Clinic	Heathlands Unit	B13 8QE
RQ330	Parkview Clinic	Irwin Unit	B13 8QE

This report describes our judgement of the quality of care provided within this core service by Birmingham Children's Hospital 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 Birmingham Children's Hospital NHS Foundation Trust and these are brought together to inform our overall judgement of Birmingham Children's Hospital NHS Foundation Trust.

Summary of findings

Ratings

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

Overall rating for the service	Good
Are services safe?	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:

- We found Parkview clinic to be well managed and staffed by a happy staff team. Patients told us about many good experiences while they have been in the service. We observed a collaborative and inclusive team who worked well with patients.
- There were processes in place to ensure safety when managing medications. Staff routinely carried out physical health checks. Carers told us they were kept informed about their child's progress and we saw family therapy interventions carried out on the ward.
- Staff within the service had a good knowledge of the patients in their care and staff across wards all worked well together. Staff were visible on wards and accessible to patients.
- We found the leadership within Parkview clinic to be strong and innovative. The staff were team constantly striving to improve the service for patients and staff.
- Staff had the opportunity to develop within their roles and give feedback on the service. Staff had regular team meetings and group peer supervision sessions. Staff were qualified, experienced and received appraisal however individual supervision was not routinely carried out and recorded.
- Patient care records were clear, concise and well documented. Risk assessments and risk management were well recorded. Care plans were holistic and personalised and fully reflected patient views.

However:

- Patients and carers told us that social activities were occasionally cancelled due to short staffing and this was disappointing for the patient. Patients also told us the food was not very good.

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:

- Wards were safe, visibly clean and well maintained.
- Clinic rooms were in order and well stocked.
- There were appropriate numbers of visible and accessible qualified staff on shift, available for clinical care.
- Staff members were up to date with mandatory training.
- Risk assessments were detailed and comprehensive.
- Use of restraint techniques was well documented and justified within care plans.
- There were excellent medicines management procedures.
- Staff regularly shared learning from incidents.

However:

- Learning and investigations following incidents needed some improvement.
- The service was occasionally short staffed and as a result some patient social activities had been cancelled.

Are services effective?

Good

We rated effective as good because:

- Staff completed comprehensive assessments.
- Staff monitored patients physical health regularly.
- Patient care plans were personalised, holistic and detailed.
- Staff offered evidence based psychological and family therapies.
- Staff were qualified and received appraisal.
- Staff had regular team meetings and actively participated in multidisciplinary team meetings.
- Staff worked well together across the units.
- There was good evidence of adherence to the Mental Health Act and consideration of capacity and Gillick competence assessment.

However:

- There was no consistent individual managerial or clinical supervision recorded by managers.

Are services caring?

Good

We rated caring as good because:

- Patients told us they were treated well by staff.

Summary of findings

- We saw positive and compassionate care from staff towards patients.
- Staff at all levels showed good knowledge about individual patients.
- Patients were fully involved in their care including care planning and management of risk.
- Carers were kept informed about their child's progress and involved in their care.
- Patients had access to advocacy services and knew their rights.
- Patients were involved in recruitment of staff.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- Staff managed patients who could result in delayed discharges from point of admission to ensure length of stay was not longer than necessary.
- Patients could personalise their own bedrooms.
- Patients could access a school on the same site as the clinic and teachers taught on the wards.
- Patients had access to hot drinks and food 24/7. Patients could access food that met specific dietary requirements.
- The clinic had disabled access.
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- Patients knew how to feedback and complain and were given regular opportunities to do so.

However:

- All patients we spoke to told us they did not like the food supplied on the unit.

Are services well-led?

Good

We rated well led as good because:

- Staff conducted their roles in line with the organisations values.
- Senior members of staff within the clinic were visible and accessible.
- Senior members of staff within the trust regularly sought to improve communication and feedback from ward to board level.
- Staff told us they were happy in their roles and there was opportunity for development within their roles.

Summary of findings

Information about the service

Parkview clinic is an inpatient child and adolescent mental health service (CAMHS) with three inpatient units.

Ashfield Unit has eight beds and provides a safe, contained environment enabling staff to manage a high degree of risk associated with the more acute phase of a young person's illness.

Heathlands Unit has 14 beds and is a general adolescent unit.

Irwin Unit has 12 beds and provides specialist treatment for patients with an eating disorder. This unit was built as part of phase one of the service redesign new build and patients moved in December 2015.

The service was last inspected on 13 August 2014 by our inspection team at care quality commission and was compliant in all areas inspected.

Our inspection team

Our inspection team was led by:

Chair: Dr Michael G. Anderson MD FRCP, Consultant Physician & Gastroenterologist.

Head of Hospital Inspections: Tim Cooper, Head of Hospital Inspection, Care Quality commission.

The team included a CQC inspector and a variety of specialists: one consultant psychiatrist, two registered nurses and a Mental Health Act reviewer.

We were also supported by an expert by experience who had personal experience of using or caring for someone who used the type of services we were inspecting.

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 these services and sought feedback from staff at four focus groups.

During the inspection visit, the inspection team:

- visited all three of the wards at hospital site and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 12 patients and nine carers of people who were using the service
- spoke with managers and deputy managers for each of the wards
- spoke with 37 other staff members; including doctors, nurses and clinical support workers
- attended and observed three hand-over meetings and two multi-disciplinary meetings.
- looked at 26 treatment records of patients
- carried out a specific check of the medication management on all three wards and checked 30 prescription charts.

Summary of findings

- 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

All patients we spoke to on all units told us that they felt safe and were treated well by staff. Patients and carers told us that the unit could be noisy at times. However, they also told us that staff were a calming influence. Some patients reported to us that they became bored on the units due to lack of social activities and occasionally activities were cancelled due to short staffing. All patients told to us that the food provided on all units was not good and inconsistent in quality. Patients told us staff really care and treatment was helpful for them.

Carers we spoke to told us they felt the support from staff was very good and they found the family therapy useful. Carers were complimentary about staff and but also told us there was a lack of activities and some were cancelled due to staffing. Carers told us that staff were friendly and approachable for both themselves and their child.

Areas for improvement

Action the provider SHOULD take to improve

- Ensure staff are offered regular supervision and this is documented with actions taken.
- Ensure staff investigate incidents thoroughly and action plans are developed from learning.
- Ensure there are enough activities during the weekend for patients who do not leave the service.
- Ensure activities are not cancelled due to staff shortage.

Birmingham Children's Hospital 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
Ashfield Unit	Parkview Clinic
Heathlands Unit	Parkview Clinic
Irwin Unit	Parkview Clinic

Mental Health Act responsibilities

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

We include our assessment of the provider's compliance with the Mental 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.

Mental Capacity Act and Deprivation of Liberty Safeguards

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.

- On the day of our inspection there were four patients detained under the Mental Health Act.
- Seventy-six per cent of staff had up to date training in the Mental Health Act.
- Patients had their rights read to them on admission and routinely during treatment. This was documented in care records.

Detailed findings

- The Mental Health Act manager arranged training in document scrutiny as needed. There was annual refresher training in Mental Health Act and Mental Capacity Act.
- Detention paperwork was in order.
- The Mental Health Act manager audited patients' records weekly. The Mental Health Act manager had a system in place to correct records where necessary.
- The Mental Health Act administration team made arrangements for patients to appeal to tribunals and managers' hearings.
- Staff were aware of and could explain the principles of the Mental Health Act and updated code of practice.
- All patients' records, with the exception of one on Irwin Unit, showed evidence of informed consent, discussion of treatment options and a mental capacity assessment.
- Patients and staff had access to Independent Mental Health Advocacy (IMHA) via National Youth Advisory Service for advocacy.
- Staff reminded detained patients of their rights under section 132. This information was available in a suitable format for the age group.

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

- There were areas where it patients could not be seen by staff on all units. Staff were aware of these blind spots. The risks associated were reduced by increased staff presence and observation on the ward. Staff did not supervise all access to rooms however if risk increased, observations were amended.
- All rooms contained anti-ligature furniture.
- All units had an up to date ligature audit. The clinical risk management and personal safety nurse along with ward managers completed a ligature risk audit. This identified any ligature points and actions needed to reduce risks they posed. The clinic had a plan to remove or replace ligature points. Staff managed these risks by use of observation.
- All units were mixed gender. Irwin Unit was the only ward with single en-suite bedrooms. The layout of the unit allowed for a therapeutic environment and therefore it was difficult to zone areas of the unit. Male and female rooms were grouped together and patients were requested not to leave their rooms in a state of undress.
- Ashfield Unit and Heathlands Unit had dormitories with two-three beds to a room. Ashfield Unit also had two additional single rooms. Both Heathlands Unit and Ashfield Unit were zoned into male and female areas of the unit. Both units also had access to communal bathrooms that did not require patients to pass rooms of the opposite gender.
- No units had female only lounges as recommended in the code of practice, however, there was enough room on each ward should patients wish to be separated. We did not identify any negative or unsafe impact on patients.
- We inspected all clinic rooms. We found them to be visibly clean and tidy. Cleaning rotas inspected were all up to date.
- There were adequate levels of stock of medication and equipment to serve the amount of patients on each ward. All medications were in date. The medications in the cupboard and the fridge were in good order. Staff audited fridge temperatures to ensure they remained within minimum and maximum range for the storage of medication.
- Staff record keeping of medication management was good. There were systems in place to access pharmacy. Staff completed clinic checks daily and we found no issues with the prescription charts.
- In all clinic rooms there was an examination couch, a blood pressure monitor and scales. Medical equipment had been calibrated.
- The resuscitation equipment was present and checked daily. Emergency drugs were present, staff checked them weekly and they were all in date.
- All clinic rooms were accessible by doctors and qualified nursing staff. Staff kept locked clinic room doors.
- There were no seclusion rooms on any of the units. Staff reported that they did not use seclusion.
- The furniture was in good condition and well kept. Furniture on Ashfield Unit was appropriate for the needs of unit i.e. lightweight and therapeutic.
- Furniture on Irwin Unit was chosen specifically for its therapeutic use i.e. the sofas in the communal lounge could be parted, moved and rearranged to create a space suitable for the needs of the patients at the time.
- Patient-led assessments of the care environment (PLACE) results for cleanliness were 100%; this was higher than the England average (98%). The PLACE results for facilities was a reduction on the year before score at 91% however was equal to the England average (91%).
- We observed domestic staff cleaning units during our inspection and examined cleaning records which were up to date and showed regular activity.
- We observed staff adhering to infection control policies with use of hand gel on entering wards. There was access to hand gel on all wards. Hand hygiene posters were displayed in some staff and visitor toilets.
- The unit managers and ward clerks carried out weekly environmental assessments of the units. They assessed any environmental issues that needed to be addressed on units. Staff would refer building issues that needed to be addressed to the estates and management team within the trust.

Good

Are services safe?

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

- Staff told us that they would report environmental issues to the estates and management team. The estates and management team classed 'urgent' as respond within 5 days whereas on occasion staff felt this should be quicker. As a result, Parkview clinic management trialled and on-site maintenance personnel. Staff found that this helped speed up the process of dealing with issues requiring attention on the unit.
- All staff carried personal safety alarms to summon assistance when needed. Personal alarms were pull or press button which alerted all units to an issue on the unit.
- We observed staff responding to an alarm call. Identified staff on all units responded to alarm calls quickly and in a coordinated fashion.

Safe staffing

- Establishment levels on Ashfield Unit for qualified nurses were 19.2 whole time equivalent (WTE). There were two vacancies. For clinical support workers the WTE was 8.2 with 0.6 vacancies.
- Establishment levels on Irwin Unit for qualified nurses were 14.0 WTE and one vacancy. For clinical support workers the WTE was 11.5 and there were no vacancies.
- Establishment levels on Heathlands Unit for qualified nurses were 18.0 WTE and there were no vacancies. For clinical support workers the WTE was 13.6 WTE and there were no vacancies.
- The highest average bank staff use in the three months before the inspection was on Ashfield Unit (20%) followed by Heathlands Unit (12%) and Irwin Unit (5%). The high proportion of bank staff use on Ashfield unit was attributed to increased staffing required to manage risks for a patient waiting transfer to a more suitable placement.
- The highest number of unfilled shifts in the three months before the inspection was on Heathlands Unit (27%) followed by Ashfield Unit (22%) and Irwin Unit (11%).
- Trust target for staff sickness were 3.4% and below. In April 2016, Ashfield Unit sickness absence was 6.4% with 5.7% attributed to long term sickness. On Heathlands Unit sickness absence was 8.1% with long term sickness at 6.8%. On Irwin Unit, sickness absence was 7.8% with long term sickness absence at 4.1%.
- Trust target for staff turnover was 9% and below. At Parkview clinic turnover was at 9.5% in the 12 months prior to the inspection.
- Staffing complement was based on assessment of the units dependency. This was based on Quality Network for Inpatient Child and Adolescent Mental Health Services (QNIC) standards and clinical judgement. Staff also conducted an analysis of incidents and when they occur to assess unit dependency.
- The head of nursing could change the staffing ratio if needed based on feedback from unit managers about risk and dependency levels on units.
- The head of nursing had created posts for support staff. This was to free up time for nursing staff carrying out non-clinical activities on the units giving more time to patients.
- The head of nursing and managers of each unit discussed staffing levels in the daily Hospital Operational Centre (HOC) meeting. All units would feedback on staffing levels, expected sickness absence and weekend cover. If needed, managers sought cover from other units if a staff shortage was indicated at late notice. This was to avoid use of bank staff.
- The majority of bank staff were sourced from a pool of staff already employed by the service, therefore they knew the service and patients well. Any staff unfamiliar with the unit were inducted and orientated to the unit by a senior member of staff and completed the trust's local induction checklist.
- Each unit had a board showing the staffing number for each day and this matched the number of staff on shift as this was fed down from the HOC meeting information.
- Staff were visible on all units and there was always a qualified nurse available in communal areas. There was a band six or seven nurse on shift at all times on all units.
- Patients had weekly care review sessions with their named nurse, however could also seek support from nursing staff throughout the week.
- Patients and staff reported that occasionally social activities were cancelled due to too few staff on the unit. Patients we spoke to told us this was upsetting as they had often been looking forward to leaving the building. We viewed previous and current working rotas, some dates were short staffed which collaborated with patient's views that activities were cancelled.

Good

Are services safe?

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

- The head of nursing told us she had tried to ensure the number of staff on units allowed for patients' activities and leave. However sometimes staff had to cancel due to clinical risk decisions. The head of nursing also told us about plans to increase numbers of occupational therapy assistants in order to support with enabling activities.
- There were two junior doctors on Heathlands Unit and one each on Irwin Unit and Ashfield Unit. There was an out of hours on-call doctors rota covering all three units. There was also access to Birmingham Children's Hospital emergency services if needed.
- Staff told us on two occasions following an incident on the unit that required medical attention, the staff were unable to make contact with the junior doctor on call immediately. We discussed this with management and found there was a tiered on-call system which allows staff to ring a senior doctor or a consultant if they cannot contact junior doctors. Staff can report concerns about the on-call contact to senior members of staff to address.
- Trust target for completion of core mandatory training and role essential training was 95%. We found compliance for mandatory training for Parkview inpatient staff was 88.4%.
- The lowest compliance rates were information governance (69%) and fire safety (70.2%). Compliance for role essential training was 74.9% which was 22.1% below target. The lowest compliance rates were manual handling practical load (52.1%), basic life support (65.9%) and manual handling practical patient (67.3%).

Assessing and managing risk to patients and staff

- There were no instances of seclusion in the six months prior to inspection.
- There were no instances of long-term segregation in the past six months.
- There were 126 incidents of restraint between September 2015 to February 2016, three of which were prone (face down) restraint.
- Ashfield Unit had the highest proportion of restraints with 85 and three in prone position. Following the three prone restraints, staff completed incident forms and patients and staff were given the opportunity to debrief. Two prone restraints were on the same patient who was detained under the Mental Health Act. The reason for the restraints were to administer medication and to prevent self-harm. The other prone restraint occurred on an informal patient following disruptive behaviour which lead to staff injury.
- Heathlands Unit had two instances of restraint and Irwin Unit had 39, none of which were in prone position.
- There were individualised care plans to address the use of nasogastric tube feeding and restraint on Irwin Unit. Restraint care plans clearly recorded the patient's preferences. The 39 instances of restraint on Irwin Unit were for one patient to carry out nasogastric tube feeding.
- Staff recorded any uses of restraint that were not part of a restraint plan on a restraint monitoring form. The information was sent to the governance team. Staff recorded all instances of restraint in the notes and carers of the patients were informed.
- We examined 26 patient records across all three units. All patient records contained and up-to-date comprehensive risk assessment. We saw staff had updated risk assessments following incidents with patients.
- Specific instances of risk and self-harm were well-documented. Incidents were outlined clearly, including where when and how incidents occurred, and the treatment that was given. There were also clear notes showing subsequent contact with parents by phone or on visits.
- All patient records included a Galatean Risk Screening Tool (GRiST). This was individualised, with care plans to match identified risk.
- There were no blanket restrictions in place on the unit. Blanket restrictions refers to rules or policies that restrict a patient's liberty and other rights, which are routinely applied to all patients, or to classes of patients, or within a service, without individual risk assessments to justify their application.
- At the time of inspection, most patients at the service were informal patients, however, Ashfield and Irwin Unit locked the entrance doors due to three detained patients present on the units. Heathlands Unit did not lock unit doors.
- We saw a clear process map for staff to follow in regarding patients who wished to leave the unit which included reference to risk assessment and care planning.

Good

Are services safe?

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

- Staff told us that informal patients were advised of their rights to leave the ward on admission. We did not see any form of notification on wards or in patient records to remind patients of their rights.
- Staff conducted searches to manage risks and only if necessary as per trust policy.
- The service had adopted nonviolent resistance techniques that are a form of systemic family therapy. Since implementing this method, staff had found that incidents of violence and restraint had decreased.
- We reviewed the rapid tranquilisation policy and found staff were adhering to this.
- Staff were trained in safeguarding children level one as part of the mandatory training and compliance was 100%. Staff were also trained in safeguarding children level two and three compliance was 88.9% 82.4% which was below trust target of 95%.
- Staff made 16 safeguarding referrals made between April 2015 and March 2016. Each unit had two designated safeguarding leads. There was a nominated safeguarding lead for the trust.
- A safeguarding nurse link worker from the trust visited the units weekly to offer training, advice and support for staff. Nominated safeguarding champions for each unit liaised with the safeguarding nurse link worker regularly.
- The safeguarding nurse link worker also facilitated debriefs for staff after incidents. They also offered staff case supervision and reflection.
- Medicines were stored in locked cupboards in a locked clinic room. A pharmacist visited the unit weekly to reconcile medications.
- Two nurses checked and administered medication at all times. This reduced the opportunity for error.
- The controlled drugs book was up-to-date and corresponded with the controlled drug order book.

Track record on safety

- There were no serious incidents reported by the service between March 2015 and February 2016.
- We saw good evidence of improvements to safety within the service as a result of incidents which had occurred both in the service and external to the service. An example of this included replacements of ineffective anti-ligature curtain rails following an incident where a patient had managed to tie a ligature.

Reporting incidents and learning from when things go wrong

- Staff knew how to report and what to report. We saw evidence of incident reporting.
- The clinical risk management & personal safety nurse specialist monitored incident reporting across all units. Following incidents he arranged an investigation to be carried out. He conducted debriefs for the staff. He then recorded the incident and outcome to head office and disseminated learning to the units by email and if necessary trust wide so other units could benefit from learning.

The highest proportion of incidents were reported at Ashfield Unit (69) followed by Heathlands Unit (27). Irwin Unit had the lowest number of incidents (14). (March 2015 and February 2016)

- The most commonly reported incident categories were regarding admission and discharge (20) and medication (20). These were followed by self-harming incidents (14).
- Ninety-seven percent of incidents resulted in low harm or no harm.
- 85% of incidents were reported to the National Reporting and Learning System (NRLS) within 30 days of the incident, occurring and 94% were reported within 60 days.
- Staff did not always learn lessons following incidents. For example, a broken clinic door lock left the room unsecured twice. Staff reported the incident both times. However, management did not take action until the second incident and no investigation was carried out on the cause of the incident.
- We saw duty of candour within patient records and on notice boards on the units. Staff had highlighted when an error had occurred and what they had done about it.
- Staff had the opportunity to discuss feedback from learning during weekly staff meetings.
- We saw evidence of correspondence sent from clinical risk management & personal safety nurse specialist to the units regarding incidents. We saw recommendations to improve safety and practice following learning from incidents.
- Staff were able to debrief directly after incidents, in supervision or in staff meetings. The unit manager or clinical risk management & personal safety nurse specialist facilitated debriefs.

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

- We reviewed 26 care records. We found notes to be exceptionally detailed and comprehensive. All notes contained detailed a pre-admission summary. This document highlighted issues and risks that have been identified pre-admission.
- SBAR - situation, background, assessment, and recommendation documentation was present in files. This was an up to date tool for assessment within child and adolescent mental health services.
- All records contained a personalised, holistic, recovery orientated care plan. Twenty-four care records we reviewed documented that patients had been given a copy of their care plan.
- There was evidence of staff reviewing care plans on a regular basis. Patients completed care plan evaluation forms and these were signed and dated by staff and patients. There were paper and electronic copies of care plans for each patient. If patients refused a copy of their care plan, staff clearly documented this.
- Clinical notes viewed were up-to-date, appropriate, accurate and legible.
- All records showed that a physical health examination had been carried out on admission. There was evidence of ongoing physical health care except in one patient on Irwin Unit who had refused.
- Staff carried out weekly or more frequent if needed, baseline observations, i.e. blood pressure, pulse and temperature. Weight was recorded on a regular basis and any variances were clearly highlighted within the documentation.
- All patient records were in paper files. All notes were stored on the respective units and were accessible by staff that needed access including bank staff.

Best practice in treatment and care

- We checked 30 medication charts across the three units. There were no errors or missed signatures on any of the medication charts. Prescribing doctors included their General Medical Council (GMC) details when prescribing.
- Medication charts contained patient identification and an up-to-date photograph of the patient. Prescription charts we viewed were written within National Institute for Health and Care Excellence (NICE) guidelines and did not exceed the maximum doses and we checked this against the British National Formulary (BNF).
- We found that PRN or 'as needed' medication had not been routinely checked within the previous 14 day period in seven out of the eight charts on Ashfield Unit. Although this was not against guidelines it was classed as good practice to review PRN medication regularly and we found evidence of this was happening on Heathlands Unit and Irwin Unit.
- One good practice therapy offered at the service was a family-based treatment of adolescent anorexia nervosa called the Maudsley Approach. This was carried out with patients on Irwin Unit. We received feedback from parents, patients and staff that was very positive about this model of working.
- There were also therapies offered across the units including recovery-orientated groups including cognitive behavioural therapy, keeping yourself safe, healthy lifestyle, body image, self-esteem, autistic spectrum disorder parents group and non-violent resistance (NVR) techniques. The service also offered individual and family therapy and had started a dialectical behaviour therapy (DBT) used in the treatment of personality disorder in line with The National Institute for Health and Care Excellence (NICE) guidance.
- We saw use of use recognised rating scales, Health of the Nation Outcomes Scales Child and Adolescent (HoNOSCA) to measure the health and social functioning of people with severe mental illness.
- Staff participated in clinical audit. For example, monthly case note audits.

Skilled staff to deliver care

- There was an excellent skill mix of staff available on the unit including consultant psychiatrists, junior doctors, nurses, clinical support workers, occupational therapists, speech and language therapists, teachers and a family therapist.
- We examined a sample of four personnel staff files from each ward. We found staff files contained evidence of interview processes. We also found evidence of appropriate training certificates and training checklists for staff. There was also evidence of role specific key skills forms.

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.

- Staff were Disclosure and Barring Service (DBS) checked by the trust and managers received notification when staff where due for renewal.
- A staff induction checklist was in place and completed for new members of staff.
- All units held weekly staff meetings. Group and individual supervision was available and qualified nursing staff had access to a preceptorship development programme. The trust target for completion of appraisal was 85%. Completion rates on Irwin Unit were 90% and Heathlands Unit were 89% which exceeded the trust target. Ashfield Unit completion rate was below target at 81%.
- Staff had weekly group peer supervision facilitated by the family therapist. However, individual supervision was not documented consistently. We found supervision was not always happening at least every six to eight weeks.
- Management systems were in place to address poor staff performance and this was reviewed through supervision and appraisal. Staff also had access to training and mentoring to address poor performance. We saw evidence of performance management in personnel files.

Multi-disciplinary and inter-agency team work

- We attended handovers on all three units. Handovers occurred between shifts and were concise, informative and clear. They were thorough and included information about risk.
- We observed a multidisciplinary team meeting around care planning and review of shift patterns in relation to the bedtime routine. The focus of the meeting was risk management and positive preventative methods.
- Staff had a good knowledge of all three units and worked together collaboratively. This was evident when we observed managers and staff move between units greeting staff and patients with ease and prior knowledge.
- Staff described effective working relationships with their child and adolescent community teams. These teams were going through a period of adjustment since they had been commissioned to deliver a new service as part of Forward Thinking Birmingham. Some band five nursing staff from Parkview clinic had chosen to leave to join the new service and Parkview clinic were in the process of recruiting their replacements.
- Staff identified that links between Parkview clinic and Birmingham Children's Hospital have improved due to staff at the acute site developing a better understanding of mental illness.
- We saw evidence of good multiagency working with the role of the complex discharge co-ordinator and NHS England, local commissioners and children's services. The working relationships set up within this role had helped reduce delayed discharges from the service.

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

- On the day of our inspection there were four patients detained under the Mental Health Act.
- Seventy-six per cent of staff had up to date training in the Mental Health Act.
- Patients had their rights read to them on admission and routinely during treatment. This was documented in care records.
- The Mental Health Act manager arranged training in document scrutiny as needed. There was annual refresher training in Mental Health Act and Mental Capacity Act.
- Detention paperwork was in order.
- The Mental Health Act manager audited patients' records weekly. The Mental Health Act manager had a system in place to correct records where necessary.
- The Mental Health Act administration team made arrangements for patients to appeal to tribunals and managers' hearings.
- Staff were aware of and could explain the principles of the Mental Health Act and updated code of practice.
- All patients' records, with the exception of one on Irwin Unit, showed evidence of informed consent, discussion of treatment options and a mental capacity assessment.
- Patients and staff had access to Independent Mental Health Advocacy (IMHA) via National Youth Advisory Service for advocacy.
- Staff reminded detained patients of their rights under section 132. This information was available in a suitable format for the age group.

Good practice in applying the Mental Capacity Act

- Seventy-six per cent of staff had up to date training in the Mental Capacity Act.
- Mental Capacity Act training was featured in Mental Health Act training and covered consent and Gillick competence.

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.

- Staff we spoke to were aware of and could explain the principles of the Mental Capacity Act.
- The responsible clinician made the decision whether a patient under 18 needs meets threshold for the Mental Capacity Act otherwise patients were treated under the Mental Health Act.
- Regular assessments of competence and capacity to consent took place in relation to all decisions including those relating to treatment. However, none of the records of assessments of competence and capacity included an explanation of how staff arrived at their decision.
- The Mental Health Act administration team reminded the responsible clinician of the need to renew detentions and assess capacity and consent.
- Gillick competence had been considered in all patient files.

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

- On all three units, we observed many instances of staff interacting with patients. We observed staff offer patients support and were responsive to the patient's presentation. At no time were patients left alone or looking distressed. Staff would approach them and support them immediately.
- We observed a member of staff playing a game with two patients and the interaction between the three was very relaxed. We observed laughter between patients and staff while on the units.
- All units had a friendly and welcoming atmosphere. The environment was markedly calm on all of the units and this appeared to be largely due to the staff's manner and treatment of patients.
- We observed a unit teaching session on Irwin Unit where patients were actively involved.
- We observed staff gently persuading patients to engage in social activities. We also observed nurses preserving dignity when the patient did not engage in mealtimes appropriately. The staff member did not draw attention to the patient and gently reengaged her in the mealtime.
- We interviewed patients on all units and their comments were all positive with regards to how staff treated them. Patients reported that they felt fully involved in their care. All patients on all units told us that they felt safe and were treated with dignity and respect by staff. Patients told us staff really cared and treatment was helpful for them. Carers were complementary about staff and told us that staff were friendly and approachable to both themselves and their child.
- Following the inspection we were contacted by one family who complained about the attitude of some staff to their child. They had raised a complaint directly to the service.
- Every patient had an individual care plan which staff followed in order to ensure the patients' needs were met. This included use of personal mobile phones in order to allow patients to maintain social networks.
- Family were able to visit patients at any time and there were no visiting hours. We saw examples on all units where staff considered the individual needs of patients on the unit.
- Carers told us that staff contacted them if there was an incident with their child.
- Patient-led assessments of the care environment (PLACE) results for privacy, dignity and wellbeing was 88%; this was lower than the England average (90%).

The involvement of people in the care they receive

- Admission to the unit included orientation for the patient and family from the point of assessment. Patients and family were able to visit the unit prior to admission to meet staff and other patients. Patients also received information in the form of booklets and leaflets.
- Patients were fully involved, if they chose to be, in their care planning and risk management plans. Carers were also involved in the care of their child through regular contact from staff and involvement in care pathway meetings. Records showed that patients were offered a copy of their care plan.
- Patients could access the National Youth Advisory Service for advocacy and there was information on all units about how to access this service. An advocate visited all of the units fortnightly and was available to talk to.
- Staff held daily meetings on all units where patients could give feedback about the service. There was also a weekly community meeting for patients to feedback. The weekly community meeting discussed what was going well, what was not going well and who patients would like to praise for doing well.
- There was a notice board displayed on all units were staff feedback from complaints or suggestions from the community meetings.
- We reviewed patient survey information between July 2015 and September 2015 and found the service received 56% positive comments and 44% negative. Between October 2015 and December 2015 the service received 50% positive and 50% negative comments.
- Positive comments were all directed and staff and their work with patients. Negative comments included suggestions to improve decoration of the unit, temperature of the unit, cleanliness of the unit and opportunities for activities.
- Patients were involved in the recruiting of staff. When recruiting staff at Parkview, potential employees were offered the chance to attend an open evening where they had opportunity to talk to patients about their experiences on the units.

Good

Are services caring?

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

- There was evidence of advance decisions in place within patient files. These included what staff should do in the event of patients experiencing low mood or aggravated behaviours.

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

- The average bed occupancy at Parkview clinic was 96% between February 2015 and January 2016.
- There were 97 admissions to Parkview between February 2015 and January 2016.
- The number of out of area placements within Parkview clinic in the last 12 months was five, all of them were on Irwin Unit.
- Patients had access to a bed on return from overnight leave.
- Patients would be moved between units if deemed clinically necessary and in the best interests of the patient. If this happened, patients and carers would be orientated to the unit gradually before being moved.
- Patients would be discharged in the morning or afternoon following a care pathway approach meeting and in co-ordination with parents or carers. The discharge co-ordinator would have set up a care package in conjunction with partner agencies in preparation for discharge.
- There were five delayed discharges between March 2015 and February 2016 with the average length of stay as delayed 141 days. This was a reduction on the previous year's figures are between March 2014 and February 2015 there had been eight delayed discharges and average length of stay 151 days.
- The unit with the highest number of delayed discharges was Ashfield Unit however the average length of stay on Ashfield Unit reduced from 76 to 46 days. This was due to the implementation of the complex discharge co-ordinator. None of the delays were due to clinical reasons.

The facilities promote recovery, comfort, dignity and confidentiality

- Patients had access to several rooms during the day. There were dining rooms and rooms for on the unit teaching. There were adequate rooms for therapies and activities on all units including a low stimulus room. There were also additional rooms within the clinic that were off the units were families could see visitors. There was a multi faith room that could be used for religious prayer or spiritual needs.
- Most families we observed visiting their child during the inspection met with patients in communal areas. We saw families using garden areas and separate lounge areas to see patients.
- Patients could see visitors in their bedrooms on Irwin Unit as each patient had an individual bedroom. This was not encouraged on Heathland Unit or Ashfield Unit as patients had shared rooms.
- Patients had access to their own mobile phones and there were areas where they could make private calls. There was a policy for patients using mobile phones and the internet. Staff monitored patients using their phones in order to protect privacy and dignity of other patients.
- There was access to outdoor space that was safely enclosed. Garden areas were well maintained and had outdoor activities and seating.
- All patients we spoke to told us that the food provided on all units was not good. They told us the taste was not good and sometimes the food could be overcooked, undercooked or not presented in an appetising way. Patients told us that the quality of food was inconsistent depending on the cook. Carers also expressed concern about the quality of meals provided to their child on the units.
- Patients reported that there was little option for vegetarian meals.
- The patient-led assessments of the care environment (PLACE) results for food 81%. This was a reduction on the year before and was lower than the England average 90%.
- We discussed the provision of meals with the service manager and head of nursing who told us that due to complaints the provider had been changed. They also commenced a feedback system in the form of placemats that could be written on once the meal had finished to give feedback on how the meal was.
- Patients had access to hot drinks and snacks 24 hours a day however on Irwin Unit and Ashfield Unit would require a member of staff to access these.
- Patients could personalise their bedrooms and had chosen to do so. Patients could access their bedrooms throughout the day as needed. Patients on Irwin Unit had their own access card.
- Patients could store possessions securely in a locked safe on the ward if required.
- We saw timetables for all of the units. Activities included therapy groups, school, community meetings, free time

Are services responsive to people's needs?

Good

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

and meal times. Some patients reported to us that there were not activities every day and that sometimes they were bored. Most patients went home at the weekend. We did not see evidence of many activities provided at weekends for patients who stayed on the unit.

Meeting the needs of all people who use the service

- There was provision for people requiring disabled access and facilities. For example, level access shower rooms and ramped access.
- Staff could access leaflets in other languages and interpreting services if required.
- All units had information about mental health conditions, treatments, health promotion, helplines, how to complain and access to advocacy services. There was also information available on autism, depression, support for carers and using the Internet safely. There were information boards on all units which displayed information about staffing, 'you said, we did' and what patients like about the unit.
- On Ashfield Unit there was information about non-violent resistance.
- There were Patient Advice and Liaison Service leaflets available and information about CQC visit, how to access Halal food, unit information and timetable of groups on all units.
- All units displayed staff photos and names.
- Ashfield Unit had a colourful display of a tree branched out to different coping strategies.
- Patients had options at meal times of vegetarian and Halal food if required. Patients could access vegan options and this as well as other specific dietary requirements with notice before admission.
- A Chaplin attended fortnightly from the Birmingham Children's Hospital site. Patients could use a designated multi-faith and spiritual room if they wished.

Listening to and learning from concerns and complaints

- There were two complaints regarding Parkview inpatients in the 12 months prior to inspection. One for Heathlands Unit and one for Irwin Unit, both complaints had been resolved by the trust.
- Action from the Heathlands Unit complaint was staff walked around the unit to ensure the environment was safe. Staff then used the findings to improve care and environment as well as leading to a phased refurbishment.
- Irwin Unit complaint was regarding the Mental Health Act. The trust carried out an investigation and the chief executive apologised to the family regarding the circumstances of the complaint. Following this, staff improved processes around informing family about patient rights.
- Patients and carers we spoke to were aware how to complain. There was access to complaints leaflets on all units.

Are services well-led?

Good

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

Our findings

Vision and values

- The organisation stated part of its mission was to be at the forefront of what is possible. We found staff on all levels had carried out extensive work constantly striving for this.
- Recent initiatives within the service such as the development of their more concise assessment process and My Care Plan approach were good examples of how the service had tried to improve with patients at the forefront. Another example was the introduction of non-violent resistance (NVR) approach and the creation of the role of complex discharge coordinator.
- We interviewed a wide range of staff across all three units and found that they all expressed both care for their patients and enjoyment of their roles.
- Senior staff within Parkview clinic were visible on units to staff and patients and knew individual patients by name.
- Staff we spoke to knew who senior managers were and could name them. There was also a clear ethos of joined up working across all units and this was evident in the way staff and managers worked and communicated. Staff worked as a team on all levels and across all units.
- The senior management and executive team had made efforts to improve the connection between Birmingham Children's Hospital main site and Parkview Clinic. They had done this by offering regular feedback sessions to staff within Parkview clinic.

Good governance

- We reviewed mandatory training levels and while staff compliance was below trust target it was still high at compliance was 82.8%.
- Completion rates for appraisal on Irwin Unit and Heathlands Unit exceeded the trust target however Ashfield Unit completion rate was slightly below target.
- Staff had weekly group peer supervision facilitated by the family therapist. However individual supervision was not documented consistently and we found supervision was not always happening at least every six to eight weeks.
- We observed adequate numbers of staff on shift during the inspection and inspected rotas which showed that staffing was mostly sufficient however also times where they had been under staffed in the past three months.
- Reports from patients were that social activities had been cancelled due to too few staff and we found that this was evident in short staffing levels on occasion.
- We attended a hospital operations centre (HOC) meeting and found that managers planned for absences as far as possible in advance.
- The head of nursing identified nurses were spending time on non-clinical tasked so introduced posts for additional band two staff to support with these.
- Nursing staff audit patient records weekly and the service was planning to introduce a self-audit tool so nurses can audit their own files regularly.
- Staff report incidents using an online clinical reporting incident form. Both the Parkview clinical risk management and personal safety nurse specialist and the governance team at Birmingham Children's Hospital reviewed this.
- The head of nursing had carried out a piece of work with staff around what constitutes a need for reporting. The governance team discussed incidents at a monthly governance meeting. The risk manager at Birmingham Children's Hospital would contact the head of nursing to discuss any risk issues where an event of harm had occurred. Management staff would complete a root cause analysis.
- Staff routinely collected feedback from patients and carers to improve the service including the implementation of the more concise assessment which they developed based on feedback about the length of assessments. The service have installed Wi-Fi access for the patients and allowed them to have their mobile phones on the unit as part of care planning.
- There was a safeguarding nurse link worker from the trust who attends the service weekly and works with staff and patients across the units in relation to safeguarding and discharge planning. They also provide training and support to staff around safeguarding issues including risk of sexual exploitation.
- Staff were aware of and follow the principles of the Mental Health Act and Mental Capacity Act.
- There was sufficient access to administrative staff for unit managers and a designated unit clerk for all units.
- Staff were able to contribute to the trust risk register through senior management.

Leadership, morale and staff engagement

- Sickness absence rates for Parkview clinic inpatient services were 5.8%, 2.5% above trust target.

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.

- There were no bullying or harassment cases reported by the trust.
- Staff felt able to raise concerns without fear of victimisation. Staff had access to weekly staff meetings where they could raise concerns and fortnightly peer meetings facilitated by the family therapist.
- All staff told us that they feel part of the team. Staff told us that they were happy with their managers and management style. There appeared to be excellent morale and staff support of each other.
- There were many examples of where staff members working at Parkview had progressed in their careers while working at the clinic and were now in senior positions.
- There were also many role development opportunities for staff working at the clinic and these were being led by the head of nursing.
- Staff told us they felt part of a team and they felt that the multidisciplinary team approach was excellent and works well together. They felt that their work was very patient focused and that staff advocate for the patients. Staff told us that the executive team were approachable and cared about the welfare of staff.
- Duty of candour was evident in the patient notes and we saw an example of the unit highlighting when things went wrong on a notice board on the unit.
- Staff were offered many opportunities to give feedback via one to one in supervision, staff unit meetings and quarterly to the board level via an open forum during visits by senior level staff including the chief executive.
- Staff we spoke to told us that there had been much improvement in the communication from leader at the main trust hospital and an attempt by them to improve understanding of the service Parkview clinic provides.
- Some staff felt that senior board level staff did not always understand the nature of the service Parkview provided. For example, health education material had been ordered by Birmingham Children's Hospital. This was not age appropriate for teenagers and was directed to younger children. However Parkview staff informed the managers of this and alternative arrangements were made.
- When recruiting staff at Parkview potential employees were offered the chance to attend an open evening where they had the opportunity to talk to staff of the same banding and to talk to patients about their experiences on the units.
- Management reported that feedback from this style of recruitment had been positive from potential employees and had also helped with retaining staff.
- The head of nursing was able manage how vacancies were used in order to create roles within the service to aid professional development and to free up duties of other members of staff.

Commitment to quality improvement and innovation

- The service were looking to achieve autism accreditation. They were putting things in place across the service in order to prepare for the accreditation including standardising use of language and terminology across the units so that when new patients were admitted if they were moved between units they know the terminology for orientation.
- The service was not involved in any quality improvement programmes or involved in research.