Watcombe Hall

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Requires improvement
Are services responsive?	Inadequate
Are services well-led?	Inadequate

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

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

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

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

Summary of findings

Overall summary

We are placing Watcombe Hall into special measures.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

We rated Watcombe Hall as **inadequate** overall because:

- The provider had not undertaken all of the actions that we told them take following our inspection in February 2016. It had not ensured that all staff had access to appropriate and regular supervision and appraisal. The provider had not ensured that staff were following up physical health observations systematically when young people declined physical health checks. There were gaps in recording of physical health observations and lack of monitoring. The provider did not consistently meet its own policy to respond to complaints within 25 days. Although the provider had reviewed what restrictions should be placed on all patients regardless of their individual risk, staff were still being inconsistent in applying these 'blanket restrictions'. We found issues around section 17 leave, consent and capacity and section 62 urgent treatment orders and delays in requesting second opinion appointed doctors to review the medication of people detained under the Mental Health Act.
- Following our inspection in February 2016, we had the rated the services as requires improvement overall but with a rating of good for caring, responsive and well led. During our follow up visit in May 2017 we were concerned enough to re-inspect all the key questions. We changed the rating in safe and effective from requires improvement to inadequate and well led and responsive from good to inadequate. The rating for caring was changed from good to requires improvement.
- The leadership of the service was not robust. The unit manager and clinical manager were both off work and there was confusion and speculation amongst staff and young people about the long term management of the unit.
- There were a high number of incidents in the service; including 18 serious incidents in the first three months of 2017. This has led to 38 staff injuries in the previous six months, staff feeling overwhelmed and staff leaving the service. Young people said they did not feel safe.
- New and agency staff had not completed an induction and staff had not had regular supervision and training. Some staff said they did not feel confident to carry out their role. Stakeholders were concerned about staff training and staff consistency.
- Young people were not attending regular education and therapy sessions. The service was 'firefighting' from one incident to another and as a result young people were bored and under stimulated.
- Governance processes had not alerted the provider in a timely manner that the service was deteriorating.
- We were concerned that the service was not meeting Regulations of the Health and Social Care Act (Regulated Activities) Regulations 2014. We issued a letter of intent to advise the provider of p
- The provider sent an action plan within the agreed timescale.
- The provider voluntarily closed the service to admissions in agreement with us and in liaison with NHS England on 11 May 2017.

The letter of intent identified the following issues:

- Watcombe Hall was not safe and the impact of multiple issues had affected the safety of the unit for children and young people and the staff.
- There were 354 incidents involving restraint in the last six months.

Summary of findings

- Patients were at risk when staff responded to incidents and had been left unobserved or had attended the incident with the member of staff.
- There were 38 staff injuries in the last six months.
- There was a lack of formal debriefing following incidents
- Staff turnover impacted on the quality and consistency of the care being delivered to children and young people.
- New staff were not adequately trained, inducted and supervised.
- Access to fresh air for young people was overly restricted and some young people were not going outside on a day to day basis. There was also a lack of therapeutic activities.

We asked the service to take immediate action on the following:

- To deploy sufficient, appropriately trained and competent staff for the safe management of the unit.
- To ensure sufficient observations of the young people to ensure they were not left unattended or required to accompany staff attending to incidents involving other young people.
- Ensure that the environment was safe. This included addressing the PICU fence, external doors and access to upstairs bedrooms.
- Ensure young people had regular access to fresh air and exercise.
- Ensure all young people to received timely appropriate care and treatment including for their physical health needs.
- We also required the provider to send us a daily update of any incidents and to provide assurance that any staff on duty had completed an appropriate induction and training.

The provider voluntarily closed the service to admissions in agreement with us and in liaison with NHS England on 11 May 2017. On 19 May, the provider submitted an action plan which confirmed that the provider had taken action to address the immediate safety issues. The provider has submitted regular action plan updates since this inspection.

We made six requirement notices for the provider to address which are detailed later in the report.

Summary of findings

Our judgements about each of the main services

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

Summary of findings

Contents

Inadequate

Watcombe Hall

Services we looked at:
Child and adolescent mental health wards

Summary of this inspection

Our inspection team

The team that inspected this service comprised two CQC inspectors including Sarah Lyle, lead inspector, a CQC inspection manager, two pharmacy inspectors and a Mental Health Act reviewer.

Why we carried out this inspection

We undertook this announced follow up inspection to find out whether the Huntercombe (Granby One) Limited had made improvements to the child and adolescent mental health wards at Watcombe Hall since our last comprehensive inspection of the location in February 2016.

When we last inspected the location in February 2016, we rated Watcombe Hall as **requires improvement** overall. We rated the core service as **requires improvement** for safe and effective and **good** for responsive, caring and well-led.

Following the February 2016 inspection, we told the provider it must make the following actions to improve child and adolescent mental health wards at Watcombe Hall:

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

These related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

Regulation 12 Person centred-care

Regulation 17 Good governance

How we carried out this inspection

During a comprehensive inspection 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, we reviewed information that we held about the location. During and after the inspection we spoke with stakeholders including NHS England and the local authority. This information and information received on the first day of our inspection from the provider suggested that the ratings of good for caring, responsive and well led following our February 2016 inspection may not still be valid. Therefore, during this inspection, we assessed all key questions; including the previous issues that had caused us to rate the service as requires improvement.

We gave two weeks' notice of the inspection on 10 and 11 May 2017. We returned to the service for an unannounced visit on 18 May with support from two pharmacy inspectors and a Mental Health Act reviewer.

During the inspection visit, the inspection team:

- visited Watcombe Hall over three days and looked at the quality of the environment for young people

Summary of this inspection

- spoke with the operational director, quality director and quality and assurance partner for Huntercombe group
- spoke with fifteen staff including the psychiatrist, psychologist, clinical team leader, nurses, occupational therapist, psychology assistant and teaching staff
- observed a community meeting
- observed two multidisciplinary meetings
- looked at ten staff records
- spoke with eight patients
- spoke with three carers in person
- looked at 50 incident records
- looked at nine care and treatment records of young people
- looked at seven Mental Health Act records
- looked at nine individual medication records
- looked at a range of policies, procedures and other documents relating to the running of the service

Information about Watcombe Hall

Watcombe Hall is an independent child and adolescent mental health (CAMHS) hospital, providing specialist care and treatment for children and adolescents aged 13 - 18 years. The service is registered for 10 young people and includes a four bedded mixed psychiatric intensive care unit (PICU). Young people could be admitted informally with parental consent, if under 16 years, or detained under the Mental Health Act (MHA) 1983.

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

Nine females were resident at the time of our inspection; seven were detained under section 3 of the MHA.

The registered manager and clinical manager were off sick at the time of our inspection. An interim operational manager, operational director and improvement team were in place, including a regional operational director and quality lead.

What people who use the service say

We spoke with eight young people and three carers during the inspection.

- Overall, patient's and carers comments were mixed.
- Most young people described the staff as very caring and supportive, although there were negative comments about the agency staff mainly due to not knowing who the staff were.
- Young people commented that staff were often too busy to support them as they were attending to frequent incidents. This left young people not feeling safe.
- All the young people we spoke with told us that they were bored and that there were not enough activities during the day, evening and weekends. They also told us that they frequently refused to attend groups and activities and did not get much opportunity for fresh air and exercise. Young people told us that this had a negative effect on their recovery.
- All the young people we spoke with told us that they did not like the food.
- Carers told us that staff were very caring. However, communication could be poor and emails were not always responded to including requests on how to complain. Carers did not always feel informed or included in the young person's care and treatment.
- Carers also expressed concern about their children and young people refusing to attend school and therapeutic activities, which they felt had a detrimental effect on their recovery and left them without enough to do.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate 

We rated **safe** as **inadequate** because:

- Due to recruitment challenges, staff turnover and sickness, there were significant numbers of agency staff working in the service. This meant that some staff did not know the young people well, which impacted on the consistency of care. Also young people were not all having their one to one sessions regularly with their named worker.
- Young people did not feel safe, such as when staff left the ward to attend to incidents.
- The environment was not safe. For example, the fence in the psychiatric intensive care unit (PICU) garden was not fit for purpose and had led to the garden not being used regularly. Young people were seen climbing over the fence during the inspection.
- Staff injuries were high with 38 injuries in the last six months.
- There had been a number of serious incidents which included overpowering staff to gain keys, forcing locked external doors and absconding. Staff felt very overwhelmed and young people said they did not feel safe.
- Staff and young people did not receive a formal and timely debrief after an incident
- There were 254 recorded incidents of restraint in the last six months. Agency staff were not trained in restraint and breakaway techniques.
- Maintenance was not timely. For example, graffiti had been reported in the maintenance book but had not been repainted until the week before the planned inspection.
- The rapid tranquilisation policy was out of date and did not reference National Institute for Health and Clinical Excellence guidance.
- Room temperatures and fridge temperatures were not consistently recorded.
- Some stock medication and syringes in the emergency equipment bag were out of date and medicines were not always ordered in a timely way, including leave medicines.
- The dispensing of medication when young people went on leave did not comply with the service's medicines policy.

Summary of this inspection

- Some practices were over restrictive and there were inconsistencies around blanket restrictions. For example, information given to young people about when they could go to their rooms and access to fresh air. This was a requirement notice at the previous inspection in February 2016.
- Twenty seven staff (50% of the eligible staff) did not have up to date level three safeguarding training, which was mandatory.
- Staff were not clear about making a safeguarding alert. This had resulted in referral delays to the lead safeguarding authority.
- There were delays in capturing information on incidents and only 39% of staff were trained to use the electronic incident recording system.
- There was inconsistent practice around use of personal alarms and some staff did not know how to use the alarms.

However:

- In March 2017, the provider conducted a safe staffing review and raised the staffing levels. Numbers had recently increased to ten staff in the day and eight at night. A minimum of two qualified nurses on shift at all times supported the high level of observations.
- The provider was working closely with the local authority and NHS England to improve safeguarding and a protocol was in the early stages of implementation.
- The provider had increased the number of block contracts with agency staff to improve consistency.
- Core training for agency staff had been arranged that included minimum restraint training and breakaway techniques.

Are services effective?

Inadequate 

We rated **effective** as **inadequate** because:

- Young people did not receive timely appropriate care and treatment including for physical health needs. Physical observations were not consistently recorded or monitored.
- There were gaps in their recording of fluid and food charts for young people with an eating disorder.
- Access to education and psychological therapies was limited and young people were frequently failing to attend these sessions.
- The main electronic record system did not contain all the relevant information. Information was stored on paper files and some on the hospital electronic drive.
- Comprehensive admission assessments were not completed for young people being admitted

Summary of this inspection

- Care records did not have full multidisciplinary input, including medical and psychology.
- Newly recruited staff and agency staff had not completed induction and did not have the appropriate knowledge for working in this setting.
- Staff had not received any specific training in the safe management of young people with an eating disorder. Staff raised their lack of knowledge about eating disorders as a concern during the inspection.
- The multi-disciplinary team were not working well together and the communication with the education team was not effective.
- Some staff had not received a recent appraisal or supervision. This was highlighted as an area of concern in the previous inspection.
- Understanding of the Mental Health Act (MHA) was a requirement notice at the previous inspection in February 2016.There remained concerns in how the MHA paperwork was recorded.
- Requests for second opinions from second opinion approved doctors (SOADs) were not always prompt. A SOAD is an MHA approved doctor qualified to give a second medical opinion for patients detained under the MHA.
- Use of section 62 for the administration of emergency medication did not fully adhere to the MHA and MHA Code of Practice. For example, a rationale for using a section 62 for the administration of emergency medication under restraint was explained but section 62 forms also listed dosage of regular medication to be given.
- Patients and carers were not routinely given section 17 leave forms when young people who were sectioned were given authorised leave. The management of section 17 was inconsistent. Leave was sometimes restricted or cancelled and there was confusion around 'earning back' leave following incidents.
- We also found gaps in consent recording for young people who were detained. For example, out of seven records there was no documentation for patients to detail whether they had capacity to consent to their regular medication and whether they gave consent to take this medication.
- Some staff (41%) were not up to date with Mental Capacity Act training. We found that up to date with Mental Capacity Act training. We found that understanding of capacity and consent amongst staff was mixed.

However:

Summary of this inspection

- The provider had introduced a new multi-disciplinary model of care to help ensure that all members of the multi-disciplinary team could work together with young people to meet their needs.
- The provider had recognised the lack of engagement in therapy and low attendance at schools. A seven day weekly planner was in the early stages of implementation to improve compliance with therapy and school.
- A staff supervision and appraisal plan to ensure regular supervision was in the early stages of implementation.

Are services caring?

Requires improvement

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

- Young people told us they were concerned about their lack of privacy and dignity during bathroom support observations.
- Young people told us they did not always feel involved in their care. A recent independent patient survey in January 2017 found that only 44% of young people felt involved in their care.
- Carers reported a lack of involvement in their child's care and communication issues, such as a lack of response to communications at times.

However:

- Most carers and young people reported that staff were friendly, kind and respectful.
- All young people said they saw their advocate regularly and knew about how to access advocacy services.

Are services responsive?

Inadequate

We rated **responsive** as inadequate because:

- The service did not clearly identify when it was unable to meet the needs of young people referred to the service. This was due to them not receiving accurate information when the young person was referred, not undertaking their own robust assessments and not feeling they could refuse to accept a young person. This had resulted in them struggling to care for young people whose needs could not be met within that environment.
- The service had a range of facilities that were under used. For example, the purpose built gymnasium had not been used since August 2016.
- Staff and young people told us that young people did not have access to fresh air and to the garden on a regular basis. Staff did not record when the garden was used.

Summary of this inspection

- There was a lack of activity and a recent independent survey found that only 11% were happy with level of activity at weekends.
- All the young people we spoke with told expressed dissatisfaction with the meals and the choice of meals provided.
- Young people told us that they were bored and did not have enough to do particularly during the evening and weekends.
- Not all carers knew how to complain and one carer told us that when they contacted staff to ask how to complain they were not responded to.

However:

- Young people were aware of how to complain and the advocate supported young people to make complaints.

Are services well-led?

Inadequate

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

- At the time of the inspection the service did not have a stable leadership team although interim arrangements had been put into place.
- Governance processes had not been sufficient to alert the provider in a timely manner of the serious concerns and provider action through the improvement team had only recently been taken.
- Staff morale was low. There was uncertainty around the arrangements for the management of the service. The absence of the registered manager and nurse manager had exacerbated this.
- Recent high levels of incidents, staff injuries, sickness and turnover had left staff with little job satisfaction and feeling of empowerment.
- Governance systems were not working effectively and results of audits were not followed up. For example, no action had been taken from medication audits that showed issues in ordering leave medicines, checking equipment and recording temperatures.
- Clinical governance was not effective in monitoring adherence to agreed plans. For example, reviews of the recording of vital patient observations did not regularly take place so it was not clear how often some young people were eating and drinking.
- Policies were out of date, such as the rapid tranquilisation policy.

However:

Summary of this inspection

- Staff and management were open and transparent about where things had gone wrong and were working hard to improve. We received assurance that the improvement team had taken immediate action and improvements included an increase in staffing, staff supervision and appraisal and training for the staff following our inspection.
- A full time interim manager was in position and was receiving an induction. Staffing levels had been increased to safe levels.
- The improvement team was working closely with the safeguarding authority to improve safeguarding.
- Staff knew how to whistle blow and were able to raise concerns without fear of victimisation.

Detailed findings from this inspection

Mental Health Act responsibilities

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

- Staff within the service were aware of how to access support and guidance from the trained staff and MHA administrator. The provider displayed a copy of the MHA Code of Practice in the main entrance for parents and visitors to refer to.
- Systems were in place for receipt and scrutiny of paperwork, including an online system, which automatically generated email reminders for Responsible Clinicians, MHA administrators and members of the nursing team when action is required, such as consent to treatment or section expiry.
- Compliance with training related to understanding of the MHA and Code of Practice was high and included on line and face-to-face training. The provider was in the early stages of rolling out a new initiative for staff to complete Mental Health Act competency assessments.
- Despite systems and training in place, we found gaps in understanding and gaps in consent, recording and prescribing. New staff had received two-hour Mental Health Act training as part of their induction but did not have an understanding of all aspects of the MHA that applied to the service, such as restrictive practice and blanket restrictions.
- Requests for second opinions from second opinion approved doctors (SOADs) were not always prompt and use of section 62 for the administration of emergency medication did not fully adhere to the MHA and MHA Code of Practice. The management of section 17 was inconsistent and leave was sometimes restricted or cancelled.

Mental Capacity Act and Deprivation of Liberty Safeguards

Most staff were familiar with Gillick competency and reviewed capacity and consent to treatment during care plan and multidisciplinary reviews. However, we found there was little detail of rationale given for decisions recorded in young people's care plans.

Overview of ratings

Our ratings for this location are:

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

Inadequate

Child and adolescent mental health wards

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

Are child and adolescent mental health wards safe?

Inadequate

Safe and clean environment

- The ward layout allowed staff to observe most areas of the two wards but there were some blind spots. These were mitigated by staff observation, mirrors and closed circuit television. Nurses were present in each communal area at all times and positioned in observation points outside bedrooms at night. Most of the young people were on high observation levels.
- The psychiatric intensive care unit (PICU) was an all-female unit and the general adolescent ward was mixed sex. At the time of our inspection, there were only female patients. All bedrooms were en-suite but there was no separate male and female corridor. The service was aware of the Department of Health guidance on same-sex accommodation and if male patients were admitted to the main ward, they were accommodated in bedrooms located at one end of the corridor. There was no separate female lounge but provision was made for male young people with use of the multipurpose room as a day areas for male patients when needed so that the lounge could remain female only.
- The two clinic rooms were clean and medicines were stored safely, resuscitation equipment and emergency drugs and were in place. There were systems in place to regularly check equipment and medication. Despite this, some stock medication was out of date and syringes in the emergency equipment were out of date.
- Monitoring and recording of medicine fridge and room temperatures was not completed daily in accordance with the medicine policy. There were gaps in the records for 28 occasions in six weeks prior to the inspection. This issue had been reported on the monthly external pharmacist audits for March and April 2017 but no action had been taken.
- Emergency medicines were accessible to staff and the expected range of medicines was available. Out of date equipment was found in the emergency equipment bags and one out of date medicine was found in the medicine cupboard in the PICU clinic room.
- There was no seclusion room, there was a room used for de-escalation on the PICU and a multipurpose room on the main ward if young people needed extra care. In the previous inspection, there were concerns that staff were not clear on how to ensure that extra care did not result in de facto seclusion. Staff we spoke with were clear that these rooms were not locked and patients were free to leave the room at any point.
- Ligature risks throughout the building had been mitigated through observation levels and the installation of anti-ligature fittings, such as anti-ligature hinges on doors. A ligature point is a place to which someone intent on self-harm might tie something to strangle themselves. Environmental risk assessments were undertaken regularly including a ligature audit and a designated health and safety lead maintained this. Recent changes had been made such as increasing the height of fire exit signs so they could not be removed.
- Watcombe Hall looked clean and there were up to date cleaning records in place, including completed weekly and daily checklists, which demonstrated that the environment was regularly cleaned. There were hand

wash gels throughout the building and hand wash signs. However, staff, young people and carers raised concerns about the cleanliness of the PICU, stating that it had been addressed in the days prior to the inspection.

- The environment was not safe for young people. For example, the fence in the PICU garden did not meet PICU specification. It was not at the required height and had spacings in the fence that allowed easy handholds. The concern about the fence appeared to have led to the garden being rarely used. On the first day of the inspection we observed a young person climb over the fence and abscond. The young person was immediately returned to the hospital by staff. There was a broken door in the kitchen used by the young people, which remained broken two days after an incident. Young people and staff raised this as a concern during our inspection as it meant that the door was not secure. We asked for this to be repaired immediately. A temporary repair had been made when we returned a week later and staff had ordered a new door. Young people, staff and carers all told us that prior to our inspection there had been a broken window, broken light fittings, poor decoration and graffiti in the PICU for a considerable period of time. For example, the graffiti had been there for over two months. These had been addressed two days prior to our inspection following the two week notification of our inspection. The graffiti had been reported by the consultant psychiatrist in the maintenance book in
- Staff had access to alarms and nurse call systems Each staff member had access to a personal alarm and a back-up system of
- Staff reported that radio alarms were not always reliable. A recent audit in May 2017 had recommended replacement of the radio alarms due to them not holding their charge when and not reaching all areas of the garden.

Safe staffing

- Twenty staff had left the organisation between November 2016 and May 2017. The average sickness rate for support workers was 10% in the last six months. The registered manager and clinical manager were off sick and the service had an improvement team and an interim manager in place
- In March 2017, the provider conducted a safe staffing review and raised the levels from eight staff to nine staff during the day and then in May 2017 this was raised to eleven staff across the two wards. The staffing levels concern had been triggered by a complaint from a young person who complained about the impact on the young people that a lack of staff was having. However, we were concerned that it took a patient to complain before the staffing levels were reviewed. The senior staff from the provider stated that staff and local management had not alerted them through the incident recording system.
- Significant use of agency staff had been necessary to support the staffing levels. We looked at the rotas for a week between 1 May and 7 May 2017. There were on average three agency staff in the evening and one agency staff during the day on each shift. Some staff were block booked but not all agency staff were known to the unit. When agency staff were used, the staff were not always familiar with the ward which the young people had commented about negatively.
- Stakeholders such as the local hospital, police and local authority expressed concern about lack of staff training.
- Young people and carers told us that regular one to ones with named nurses had not always taken place.
- The provider gave evidence that leave had been cancelled at least five times in the last three months due to staffing levels. Young people, some staff and carers told us that it was more frequent than this although we found no documented evidence to support this.
- Staff reported that they were not always able to take breaks and worked over their contracted hours. For example, on 07 May 2017 the daily rota showed that the staff team had no breaks between 20:15 pm and 07:00am.
- The provider had set and agreed the numbers and grades of staff required to cover the recent high level of observations and the staffing ratio had recently improved. When we returned to the unit on 18 May 2017, staff confirmed that they had been able to take regular breaks. We checked between 8 May and 15 May 2017 and saw that agreed staffing had been maintained.
- Following our inspection the provider informed us that 20 staff had been recruited to start work in another adolescent unit due to open nearby managed by the provider and the staff were in the process of induction. The interim manager explained that these staff would be used to cover the gaps in staffing and would reduce the need for agency staff in the short term.
- There was medical cover in the day with a consultant and responsible medical officer and a provider wide on

call system at night. The service also had access to local out of hours GPs and a GP with special interest carried out physical checks such as blood tests and other medical checks at a local surgery.
- The psychiatrists did not usually see young people outside of the weekly ward round despite that availability of medical staffing.
- Staff received mandatory training and the compliance with mandatory training was 75%. All staff had completed the security induction and more than 90% of staff had completed recent training such as breakaway techniques and restraint. However, with some mandatory training only half the eligible staff group had completed the training. For example, duty of candour and level 3 safeguarding training.

Assessing and managing risk to patients and staff

- There were a high number of incidents of staff restraining young people. In the last six months, there were 254 incidents of restraint.
- One hundred and sixty incidents of restraint were in the PICU and involved nine young people. The high levels of restraint were mainly concentrated on three patients of these nine patients with 29 or more episodes of restraint each.
- In the main ward, with the exception of one patient who was restrained on 37 occasions, more patients were restrained but less frequently. Records showed that 14 patients were restrained on 57 occasions in total.
- There were no recorded incidents of prone restraint and staff told us that did not take place.
- There were high staff injuries and 38 staff had been injured in the last six months following assaults by young people or during the nigh numbers of restraints of young people. One member of staff had been off sick for a month with an injury and was injured again on the first day of their return to work.
- We reviewed all nine care records and saw that most risk assessments were up to date with identified risks matched to management plans. However, the risk inventory was not completed for one patient.A risk discussion took place for each patient in the weekly MDT and individual risk assessments for each patient formed part of the multi-disciplinary team checklist.
- The wide use of blanket restrictions was a requirement notice in the previous inspection in February 2016. We found blanket restrictions were still widespread and that understanding of blanket restrictions was mixed. There had been some improvements, such as ensuring that potential restrictive practices were discussed at team meetings and community meetings. There was evidence that changes to practice had occurred such as access to drinks and type of crockery was assessed according to individual risk and choice.
- There was confusion between staff and young people about blanket restrictions and access to fresh air and the information given to young people differed between staff members. For example, one young person told us that she had been allowed to wear makeup to attend education classes, when previously she had been told that she could not. Young people and staff were not clear about the time of the evening curfew. Three young people told us they could go to their rooms at 8pm but not before. Staff members told us the curfew was 10pm others said midnight. Young people and staff listed different items that they thought were banned. We asked the staff and young people if the provider had a definitive list of banned items but staff were not able to show us one.
- One young person was still on restricted leave since an incident in February 2017, three months before, and remained on high observations despite no further incidents.
- The clinical team at Watcombe Hall were concerned about management of their risk, and had asked NHS England to place some young people in a different inpatient service. However, the lack of garden access, restricted leave and some young people's refusal to engage in activities offered meant that they were effectively not leaving the unit and some patients had engaged in no activity for three months.
- There were signs to indicate that informal patients could leave at will. Signs displayed on some of the locked doors informed patients to ask staff if they wished to leave.
- Staff were trained in how to restrain young people safely and 94% of staff had completed recent training.
- The rapid tranquillisation policy in place dated April 2010 was under review. It did not reference National Institute of Health and Care Excellence (NICE) guidelines (Violence and aggression: short term management in mental health, health and community settings April 2015) and referred to medicines that were not recommended in NICE guidelines.
- A corporate medicines management policy covered all aspects of medicines management. However, this was

not consistently followed. For example, refused doses were recorded on the medicine charts but they were not always recorded on the disposal record in accordance with the medicines policy. There were a number of omissions recorded on medication charts when medicine was out of stock. This was usually only one missed doses. However, one medicine was out of stock for five days. This medicine needed to be ordered in advance. The medicines policy stated that in exceptional circumstances, the service could dispense medicines for short-term leave 'in-house' However, this was a routine occurrence and the service was not following their medicines policy concerning written authorisation, the dispensing process or records of supplies of medicines.

- We also found that the administration of medicines administered on a 'when required' basis exceeded the maximum prescribed dose on two occasions. There was no patient specific care plans available to guide staff when to use 'when required' medicines.
- Four patients had injectable rapid tranquillisation medicines prescribed on their medicine chart. Two prescription charts showed that medication not recommended by NICE had been prescribed if required. However, this had not been given.
- Fifty percent of staff had not received level three safeguarding training. Eight staff did not know the level of child protection training that they had completed. On 27 January 2017 a section 11 meeting with the local authority raised concerns regarding the management of safeguarding referrals. Whilst the service is now working closely with NHS England and the local authority to address the concerns, the section 11 meeting minutes and action plan was in the managers in box for four weeks before staff were aware it was there, which meant that there was a delay in implementing the action plan. This was due to the manager's mailbox not being monitored whilst they were unwell.
- During the inspection we asked the service to make a safeguarding referral to the local authority regarding the bruising to the upper arms of a young person. Staff were not aware of bruising and had not checked for bruising following a restraint until the bruising was shown to the CQC inspector by the young person. Staff did not regularly record on incident forms whether they checked for injuries. In another safeguarding incident, the referral to the local authority safeguarding team was not completed, as various staff believed that other staff had completed this. There was no system in place to monitor this.
- The provider in conjunction with NHS England and the local authority and hospital had developed a shared protocol to improve safeguarding practices. This was in the early stages of implementation.

Track record on safety

- There were ten serious incidents in 2016 requiring investigation within the NHS commissioning framework. In the first three months of 2017, 18 serious incidents were recorded.
- Incidents were logged onto an electronic incident system. However, there was a delay with uploading some incidents. For example, two incidents in January had not been uploaded until mid-May 2017.

Reporting incidents and learning from when things go wrong

- We looked at 50 incidents reported on the electronic incident system in the two weeks 27 April 2017 to 11 May 2017. The staff team did not code six of the last ten incidents recorded correctly and 15 had not been quality checked or investigated.
- Some staff we spoke with had not been trained in using the incident system. Records confirmed that only 39% of staff team had completed this training. Training for this was not included on the service wide training matrix.
- There were high numbers of incidents including a recent incident of overpowering of staff to gain keys and absconding by young people. We had concerns that not all incidents were being captured on the recording system.
- Incidents were discussed at multidisciplinary meetings and weekly reflective practice sessions facilitated by the family therapist. However, the recent rapid number of incidents meant that there was no opportunity to discuss all the incidents and in any depth. Staff members told us they did not routinely get any feedback on any incidents they raised. Nine staff members told us they did not get a formal debrief after an incident. For example, a staff member was visibly upset regarding a recent serious incident when talking to one of our inspectors. They had not been offered formal debrief and had remained on duty for the remainder of shift.

Inadequate

Child and adolescent mental health wards

- Young people reported that they were not offered formal debrief after incidents. It was reported that because of staff responding to incidents involving a young person, other young people were left alone without any observation and young people reported that they did not feel safe when this happened. For example, a young person told us that they had harmed themselves whilst staff were responding to an incident. The incident had involved three young people overpowering staff and then absconding. The same three young people also forced the door of the unit open the weekend before our inspection. Police assistance was required to help return young people to the hospital. Other young people who were on close observations reported having to respond with staff to incidents. This included having to stand in sight of the staff who were meant to be supporting them whilst the staff member was either conducting a restraint or cutting a ligature off another young person. Young people reported this was distressing.

Are child and adolescent mental health wards effective?

(for example, treatment is effective)

Inadequate

Assessment of needs and planning of care

- We reviewed all patient care plans. Aspects of the care plans were updated frequently and we saw examples of this when young people's needs had changed.
- Care plans were personalised and holistic, but did always include young people's views or words or demonstrate their involvement. One care plan was restrictive and did not appear to involve collaboration with the young person. At the time of our inspection a young person had recently been treated for suspected norovirus.A care plan had been formulated with actions the staff needed to take. However, this had not been updated since the quarantine period had passed.
- Care records did not have full multidisciplinary input with very few entries from the consultant psychiatrist in the clinical records who stated that they had only started seeing young people outside of weekly ward round on the 8 May following requests from young people to see them more often.
- Five care records did not show that a physical health examination had been undertaken on admission and that there was on going monitoring of physical health problems.
- One record of a patient who was admitted two months prior to the inspection for an assessment of their mental health did not have an assessment recorded or a formulation by the psychiatrist in the records and the CPA documentation was blank for psychiatry.
- Some records were not stored on the main patient record and we came across three systems when we tried to find care information. The main electronic record system did not contain all the information as some was stored on paper files and some on the hospital electronic drive. This posed a risk as staff were not able to identify where information about young people were located.
- A recent internal care plan audit had identified involving patients in care plans as an area for improvement. A plan to implement a CAMHS model including teen star assessment tool was in the early stages of development.

Best practice in treatment and care

- Physical observations of young people's health were not consistently recorded by the ward team or monitored by the medical team. For example, one young person on the unit had not eaten or drunk anything for four days. Medical staff had requested physical observations on 10 May 2017. No observations had been completed by 2pm the following day. This had not been monitored by the medical staff.
- At the daily ward round on the morning of 11 May 2017 the medical staff did not review in detail whether observations had been completed. The fluid/food intake charts for patients with eating disorders did not accurately record the length of time of no food fluid/ intake. At the ward round staff were only instructed to 'take vital signs and encourage fluids'. When the observations were completed on the afternoon of 11 May 2017, following our request, the young person showed signs of tachycardia (a fast pulse rate indicating increased heart rate).
- The recording of weight was also inconsistent. One young person with an eating disorder had only been weighed twice since admission when doctors had requested this twice weekly. There had been no monitoring of this by medical staff.

- Torbay Hospital had raised concerns about the number of young people admitted from Watcombe Hall with malnutrition and dehydration. For example, one young person was admitted three times in three days this year. Staff had not received any specific training in the safe management and treatment of young people with an eating disorder. Staff raised their lack of knowledge about eating disorders as a concern during the inspection. There were two young people with eating disorders in the unit at the time of our inspection.
- Staff used recognised rating scales to assess and record outcomes such the health of the nation outcome scales for children and adolescents (HoNOSca) and the children's global assessment scale (CGAS). There was a commissioning requirement to demonstrate use of HoNOSca and CGAS to determine patients' health and social functioning.
- The service was in the early stages of implementing an outcome focused model with an emphasis on young people involvement and engagement. Family therapy was offered for all the young people and their families and we saw evidence of regular involvement.
- There was a lack of therapeutic engagement and education. Young people were only scheduled for two hours education and one hour of therapy in the PICU during the day. In the main ward they were scheduled for two therapy sessions per day and one education session. However, these were often cancelled and young people frequently refused to attend or were asleep. For example on the two days of our inspection, there were no therapy groups to observe.
- Audit processes were in place, such as infection control and medicines management including controlled drugs, prescription charts and storage of medicines but issues were not always followed up.

Skilled staff to deliver care

- The registered manager and clinical manager were both off sick at the time of our inspection. An improvement team was in place consisting of quality lead operational director and an interim clinical manager.
- Since the last inspection the service had recruited a permanent responsible clinician and a family therapist. An associate specialist doctor was in place and a part time locum social worker.
- An occupational therapist and psychologist were in place. These staff and some nursing staff were learning disabilities trained staff that had transferred with the organisation when the service became a CAMHS unit. The provider had given all staff in house CAMHS training through a programme of shadowing and support at the provider's larger CAMHS unit it Maidenhead.
- The provider had fully recruited to recent support worker and staff nurse vacancies and was actively recruiting a CAMHS social worker.
- Some staff had not completed a full induction, for example, four new support workers recruited between March and May 2017 had not been completed their induction. This left new staff without appropriate training.
- We reviewed ten staff records and supervision records. Records showed that individual supervision was inconsistent and only 60% of staff had received regular formal managerial supervision in the past six months.
- At the last inspection we recommended that the provider should ensure that they have access to appropriate and regular supervision.
- Staff told us that they rarely had time to attend staff meetings and that supervision was inconsistent. Three out of eight staff had not had supervision in the last two months. Staff told us that they did not have enough regular supervision and some staff felt they needed more support. External clinical supervision was in place for psychiatry, psychology and occupational therapy. Reflective practice was facilitated by the family therapist and this took place most weeks although staff and managers told us that attendance was poor due to staffing pressures on the ward.
- At the previous inspection in February 2016 appraisal rates were low. The registered manager had informed NHS England specialist commissioners they had implemented an action plan to complete all baseline appraisals by the end of March 2016. However at this inspection we found that appraisal rates had not significantly improved and only 50% of staff had received a recent appraisal.
- Poor staff performance was addressed promptly and the leadership team gave clear examples of where disciplinary action had taken place. We also saw examples of action taken to improve performance in recent staff supervision records.

Multi-disciplinary and inter-agency team work

- Weekly multi-disciplinary meetings took place and daily multi-disciplinary handovers. We observed a daily multi-disciplinary meeting. This was well attended and

included psychology, psychiatry, occupational therapist, nursing and support staff. The team discussed each young person in detail and had a sound knowledge of their needs. However, the staff team did not have clear information about the length of time a young person had not eaten or a plan to address this other than to monitor. For example, one young person on the unit had not eaten or drunk anything for four days.

- Throughout the inspection staff spoke about clear strains on the relationships between all the different professional groups, which meant the team was not functioning well. For example education staff did not attend the daily meeting and reported that communication between education staff and ward staff was poor, which resulted in an inconsistent approach to young people's education and activities.
- The service was working with the local safeguarding team and local district general hospital at Torbay. The service had recently improved partnership working with Torbay Hospital and the paediatric liaison team. A joint policy was in the process of ratification following recent learning from a serious incident.

Adherence to the MHA and the MHA Code of Practice

- Systems were in place for receipt and scrutiny of paperwork, including an online system, which automatically generated email reminders for Responsible Clinicians, MHA administrators and members of the nursing team when action was required, such as consent to treatment or section expiry.
- We made a requirement notice at the last inspection to improve Mental Health Act and Code of Practice training and understanding. This had improved and the majority of staff had attended recent training. Eighty-three per cent support staff and 100% of doctors, nurses and MHA administrative support staff had completed a one day training course. A plan for refresher training and updates was in place. The service had recently launched flash cards with bite size information for staff, including the MHA and a provider wide MHA competency assessment was in the early stages of being rolled out across Watcombe Hall. Staff employed after March 2017 had not yet received this training. However, new staff had received a two hour Mental Health Act training as part of their induction.
- Despite the improvements, we found that some new staff did not have an understanding of all aspects of the MHA that applied to the service, such as restrictive practice and blanket restrictions. We also found gaps in consent, recording and prescribing.
- Second opinion approved doctors (SOAD) requests following the use of section 62 were not always prompt. For one patient a section 62 form was completed 27 April 2017 but the SOAD request was not sent until 8 May 2017. Another patient was treated under a section 62 on 24 April 2017 and then three days later on 27 April the SOAD request was made.
- Treatment authority cardswere not routinely stored with the patients' medication charts. One of six treatment authority cards was kept with the medication records.
- Three young people who were initially assessed to have capacity to consent and were treated under a T2, which was t. On the day of our visit the young people had been treated under section 62 The rationale for using a section 62 was for the administration of emergency medication under restraint yet each of the three section 62 forms also listed dosage of regular medicine to be given.
- There was no documentation for patients to detail whether they had capacity to consent to their regular medication and whether they gave consent to take this medication. For one patient we could not find a capacity assessment despite them being treated on both a T2 and section 62. Two out of the three section 62 forms contained medicines not originally included on the T2.
- Section 17 leave was authorised through a standardised system and contained specific conditions. There was evidence that staff involved patients with leave decision making and all leave records were signed by the young people or it was recorded that they had declined to sign the form. However, only two of the forms indicated that the patients received a copy of the leave form and none of the leave forms indicated that carers received copies despite some of them being listed as escorts for leave.
- There was confusion about the policy surrounding leave and how this was applied, including how to 'earn back' leave following incidents. If a young person had been involved in an incident, their leave would be cancelled and they had to earn it back. For example, one young person had not had their restricted leave reviewed for three months and had only had one section 17 leave since an incident in February 2017. High observation levels had continued despite no further incidents.

Inadequate

Child and adolescent mental health wards

Although senior staff said this was done on an individual basis, the rationale was unclear and both young people and staff found them unclear and thought they were unfairly or inconsistently applied. Staff did not clearly document the rationale for decisions in the care records.

- Some carers raised concern that the amount of time given for leave was sometime impracticable. For example if the young person was currently allowed one hour of leave, it was difficult for the parents to do anything as it was a least 15 minute drive to the town.

Good practice in applying the MCA

- The Mental Capacity Act (MCA) does not apply to young people aged 16 and under. For children and young people under the age of 16, the young person's decision making ability is governed by Gillick competence and Fraser guidelines. The concept of Gillick competence and Fraser guidelines recognises that some children under 16 may have sufficient maturity to make some decisions for themselves.
- MCA training was mandatory. However, only 59% of staff were up to date with this.
- Capacity to consent to treatment was considered once a child reached 16 and from the age of 14 the team would consider Gillick competence. Records showed that consent was recorded in care plans and was discussed in weekly multi-disciplinary meetings. Capacity and consent to treatment and medication were reviewed and prompts for this were included in the ward review template. However, there was a lack of detail in the rationale for the decisions recorded. For example, one patient was documented as having "partial" capacity to consent to admission with no rationale to explain this. When we spoke with staff we found that understanding about capacity and consent was mixed.

Are child and adolescent mental health wards caring?

Requires improvement

Kindness, dignity, respect and support

- There were negative comments from young people about some of the agency staff mainly because young people did not know the staff. They said this was particularly difficult when staff they did not know undertook bathroom support.
- We were concerned about the number of young people who were on bathroom support. Bathroom support was described by unit staff as, 'observation of young people using bathroom facilities such as showering, bathing and using the toilet'. On day two of the inspection five of the nine young people were on bathroom support. Young people said they found it uncomfortable being observed in the bathroom particularly by staff they had never met before as this role was often undertaken by agency staff. We were concerned about this lack of privacy and dignity for the young people.
- Carers told us that communication from staff could be poor and this included not responding to email requests on how to complain.
- Despite the concerns, we saw that staff at all levels were committed to the young people, were caring and wanted to provide good quality care. We observed staff to be caring, warm and respectful to the young people. Comments from young people and carers were positive about the care they received from the substantive staff. They described them as friendly and kind.

The involvement of people in the care they receive

- Young people could give feedback on the service they receive, through daily and weekly community meetings. The young people together with the provider had recently agreed a new outcome based tool and the new model of care, which was in the early stages of implementation.
- The January 2017 provider wide patient survey carried out by an independent organisation found that only 44 % felt involved in their care. Carers we spoke with reported that they did not always feed involved in their child's care.
- All services users said they knew about how to access advocacy.

Are child and adolescent mental health wards responsive to people's needs?

(for example, to feedback?)

Inadequate

Child and adolescent mental health wards

Inadequate

Access and discharge

- The service had not always received accurate admission information and this had an impact on patient safety and the ability for staff to manage the unit safely. Referrals did not always contain complete information. For example, a referral for a young person admitted for self-harm and suicide attempt did not disclose a previous history of violence including the organisation of a riot in another service.
- The service had three patients who were on the waiting list to be transferred to units that could better meet their needs. The service was monitoring placements that were considered not suitable for the unit to manage and was working with NHS England on a priority list of young people to be moved.
- The service was not adequately assessing new referrals. Assessments were not being carried out for planned admissions and records of the decision making for the emergency admissions were not being completed on the NHS England referral and admission paper work. This meant there was no clear consideration of whether the service could meet the needs of young people or how they would affect the acuity of the ward. Senior staff told us that they felt it was hard to refuse referrals.

The facilities promote recovery, comfort, dignity and confidentiality

- The service had a range of facilities including large gardens, access to a private beach, an occupational therapy kitchen and a purpose built gymnasium.
- Young people did not make full use of the facilities available and there was a lack of activity for young people. With only 3 sessions timetabled each day, which were often cancelled or refused. With the infrequent garden access and the difficulties surrounding section 17 leave, it meant that young people primarily sat on the wart
- Staff did not facilitate opportunities for regular exercise for the young people. The onsite gymnasium had not been used by the young people since August 2016 due to a lack of staff with the appropriate training.
- All young people told us that they were bored and that there was nothing to do during the evening and weekends. The independent survey carried out in January 2017 supported this and found that only 11% were happy with level of activity at weekend. The service had not acted on this information.
- Staff and young people told us that access to fresh air access and access to the garden was infrequent. Staff had not recorded when the garden was used. There was confusion as to why the gardens were not used, some young people and staff said it was due to staffing, others due to the gardens not being secure. Different staffing ratios were given for the staffing of the gardens. Young people on the PICU said the garden was never used and that they went out for the first time whilst our inspectors were present. During that access one young person absconded from the garden and was returned by staff. One staff said that they could only recall the garden being accessed on four occasions in the previous two months, including the use on our day of inspection.
- The service offered a room for families to visit, which could be booked. Families were asked to book in advance and one parent reported that this usually worked well.
- There was space for young people to make calls in private and the unit provided a phone for this if needed.
- Most young people we spoke with expressed dissatisfaction with the meals. They told us they were repetitive and unimaginative. One young person said they did not like spicy food and the two choices for evening meal were often spicy so they could not eat their evening meal. A provider wide independent survey carried out in January 2017 found that all young people were dissatisfied with the quality and choice of the meals provided. Whereas in 2015 patient survey reported very high satisfaction rates both with choosing the menu options and the quality and quantity of the food. Young people also reported concerns with the meal sizes saying that they were small and often left them hungry. They stated that there was often no desert provided. However, young people were happy with the availability of drinks and snacks and a provider wide independent survey carried out in January 2017 confirmed this. The survey found that all young people were happy that drinks and snacks were available outside of set meal times.
- Staff members were inconsistent about young people's activities when not in education. Some staff allowed the

young people to play cards and watch TV when they did not attend education and other staff did not. On the second day of inspection, two young people who had refused education were seen playing cards with staff members. The education staff told us communication with the support workers was poor. There was a timetable of relaxation in the evenings which had been put together in part by the education team but they said they had no way of ensuring it was delivered.

- Young people could personalise their bedrooms and we saw posters and other personal items were in patients rooms.
- Staff stored patients personal belongings in designated cupboards, belongings were inventoried on arrival at the hospital.

Meeting the needs of all people who use the service

- Adjustments for people requiring disabled access could be made with use of a ground floor room except in the PICU where all rooms were on the first floor.
- Arrangements for access to interpreters and / or sign language interpreters were organised through the provider.
- The service had provided food to meet dietary requirements such as catering for a vegan diet although young people had complained that the food lacked variety.
- Information notices were on display which included details on the advocacy service. There was a patient involvement and information on how to complain. Patients' rights and information about services such as family therapy where displayed in the main reception. Information was displayed in therapy rooms about healthy living and recovery.
- Arrangements for meeting religious and cultural needs were included in the welcome pack for young people and their families. Young people were supported with religious cultural and dietary needs.

Listening to and learning from concerns and complaints

- A provider wide independent survey carried out in January 2017 found that all service users knew about how to raise a complaint. The advocate supported young people with complaints and raising concerns. There was information on how to complain in the welcome pack for young people and their carers.
- We reviewed 11 most recent complaints from March 2017 to date. Five complaints had exceeded the provider wide policy to investigate within 25 days, which was similar to a finding in the previous inspection in February 2016. Complaints were assigned to staff that were off sick to investigate and had been reassigned only recently. The longest delay was a complaint from the end of January, which had not been resolved to date (May 2017). However, the complaints that had been addressed in a timely manner showed that staff team had fulfilled its duty of candour. All six complaints had been resolved at a local level. No complaints had been referred to the ombudsmen. One complaint had been fully upheld. This complaint dated March 2017 was from a young person about the lack of staffing, and the lack of staff breaks. On April 2017, the staffing levels were increased from eight staff to nine and then a month later to eleven staff across the two wards because of this complaint.
- One carer told us that they did not know how to complain and another told us that a request for information on how to complain had not been responded to.

Are child and adolescent mental health wards well-led?

Inadequate

Vision and values

- Huntercombe values were displayed across the service. Staff were mainly aware of the visions and values of understanding, innovation, people first, towards excellence, reliable, and accessible.
- Most staff knew who the senior managers were and there had been regular visits from the senior management team at Huntercombe.

Good governance

- The service had monthly governance meetings that were well attended. The role of the governance team was to provide scrutiny, oversight and governance of the service. However, the oversight had not been effective in ensuring that staff had received regular mandatory

training, supervision and appraisal and recommendations from audits had not always been followed up. For example, medicines errors were recorded but analysis had not taken place.
- The most recent pharmacy audits reported that room temperatures and fridge temperatures were not consistently recorded. This had been reported for three consecutive months but no action had been taken.
- Clinical governance was also not effective in monitoring adherence to agreed plans such as patient observation charts.
- Some policies were out of date, such as the rapid tranquilisation policy, which did not make any reference to relevant NICE guidelines.
- Incidents were frequently not coded correctly, as the majority of staff had not received training to complete incident records. Therefore, staff could not learn from them and effectively prevent reoccurrence.
- The management did not monitor whether safeguarding referrals had been made appropriately. For example, a referral to the local authority safeguarding team was not completed, as various staff believed that other staff had completed this. However, the improvement team was working closely with the safeguarding authority and other agencies to improve safeguarding and share learning across the team.

Leadership, morale and staff engagement

- Although the improvement team brought in by the provider had begun to identify and address some of the concerns we found during the inspection, the concerns that we identified were systemic and the provider had not fully understood all of the issues. However the improvement team were open and honest with our inspectors and recognised the seriousness of the concerns and worked on action plans to address the issues raised.
- Morale was poor and staff were unclear about the future team management plans as both the registered manager and clinical manager were off work.
- Staff had felt unsupported despite an interim manager and improvement team being in place. We noted that the improvement team had taken immediate action and improvements included an increase in staffing, staff supervision and appraisal and training for the staff. On the second week of our inspection we saw that improvements had been made for the young people, which included the environment and activities.
- Sickness and absence rates were monitored and the service worked with human resources to support staff to return to work.
- Staff knew how to whistle blow and told us that they felt able to raise concerns without fear of victimisation. The service had responded to recent staff concerns and this had resulted in the arrival of the improvement team.
- Following our inspection in May 2017 the provider informed us of a number of improvements through regular action plan updates. Immediate improvements included the use of a gym instructor so that young people could access the gymnasium and trips to the local community had been built into weekly recreational plans.
- The provider was working with NHS England to arrange alternative placements for young people who were inappropriately placed at Watcombe Hall.

Commitment to quality improvement and innovation

- The service was a member of the Royal College of Psychiatrists' quality network for in-patient CAMHS to demonstrate and improve the quality of inpatient child and adolescent psychiatric in-patient care through a system of self and peer review. The most recent review took place in October 2016 and had not identified problems in the quality of care.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

- The provider must put in place a strong and stable leadership team to ensure any improvements are sustained going forward.
- The provider must ensure that governance processes are robust so that challenges are identified early and improvements are made where needed.
- The provider must deploy sufficient, appropriately trained and competent staff for the safe management of the unit.
- The provider must ensure that the environment is safe. This includes addressing the PICU fence, external doors and access to upstairs bedrooms without blanket restrictive practice.
- The provider must improve access to fresh air and exercise for young people.
- The provider must ensure that all young people receive timely appropriate assessment, care and treatment including for physical health needs.
- The provider must review and improve the recording and monitoring of young people's physical health observations and ensure they receive the appropriate input where needed.
- The provider must ensure that all safeguarding referrals are completed in a timely manner and all staff under-take appropriate training.
- The provider must review and improve incident-recording processes and ensure all staff are appropriately trained.
- The provider must review use of all blanket restrictions including inconsistent approaches by staff and the widespread use of bathroom observations, which compromise young people's privacy and dignity.
- The provider must review medicines management arrangements including recording medicine refrigerator temperatures and medicine room temperature and timely ordering of leave and stock medicines.
- The provider must ensure that medicines are administered in accordance with the prescription and prescribed maximum doses of 'when required' medicines are not exceeded.
- The provider must ensure that all staff have adequate training to meet the needs of young people using the service including a thorough induction also available for non-permanent staff.
- The provider must ensure that staff receive adequate, regular supervision and appraisal.
- The provider must ensure all staff are offered formal debriefing following incidents; this also includes offers of debriefing to young people.
- The provider must ensure that clinical records are stored in line with best practice and easily accessible.
- The provider must ensure that all staff fully adhere to the MHA and the MHA Code of Practice.
- The provider must review and make improvements to the admission procedures and ensure that it can meet the needs of young people referred to the service.
- The provider must review and improve therapeutic input.
- The provider must review and improve activities throughout the day, evening and weekends including working effectively with the educational staff.

Action the provider SHOULD take to improve

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

- The provider should ensure that checking processes for medicines and emergency equipment are completed thoroughly so that all emergency equipment and medicines are in date and fit for use.
- The provider should ensure that the results of audits are acted upon.
- The provider should ensure that all medicines sent for disposal, including refused doses, are recorded on the disposal documentation in accordance with the service's medicines policy.
- The provider should ensure that there are patient specific care plans available to guide staff on when to use 'when required' medicines.
- The provider should ensure that copies of T2 forms are kept with the prescription chart so that nurses can refer to them when they administer medicines.
- The provider should ensure that the rapid tranquillisation policy is updated and referenced to relevant NICE guidelines.

Outstanding practice and areas for improvement

- The provider should ensure that staff administering medicines have completed medicines management training modules and have been assessed as competent to administer medicines.
- The provider should ensure that staff receive specific training in the safe management of young people with an eating disorder.
- The provider should improve the meals and meal choices for young people and monitor this to ensure improvements have been made.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The care and treatment of young people did not adequately meet their needs.** **The provider had not ensured that all young people received timely appropriate care and treatment including for physical health needs and therapeutic and recreational activities.** **This was a breach of Regulation 9 (1) (2) (3) (a) (b)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **Service users were not treated with dignity and respect with widespread use of bathroom observations.** **The provider had not ensured access to bedrooms during the day and access to regular fresh air and exercise.** **This was a breach of Regulation 10 (1) (2) (a) (b)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider had not ensured safe care and treatment with an unsafe environment that included the unsuitable PICU fence.**

This section is primarily information for the provider

Requirement notices

The provider had not ensured that medicines were safely managed.

The provider had not ensured that staff fully adhered to the MHA and the MHA Code of practice.

This was a breach of 12(1) (2) 9a) (b) (d)(e) (f) (g)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not ensured that service users were protected from abuse and improper treatment through lack of management of safeguarding referrals and not ensuring staff were up to date with safeguarding training at the appropriate level. This was a breach of Regulation 13 (1) (2)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had not ensured that challenges were identified early and improvements were made promptly. The provider had not ensured a stable leadership team at Watcombe Hall. The provider had not overseen the recording, monitoring and storage of essential care and records including incident records, observations and care plan records. The provider had not ensured that staff were formally debriefed after incidents. The provider had not overseen the assessments of admissions to the unit. This was a breach of Regulation 17 (1) (2) (a) (b) (c) (d)(f)

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider had not deployed sufficient appropriately trained and competent staff. The provider had not ensured that all staff including non-permanent staff had received adequate training, supervision and appraisal. This was a breach of Regulation18 (1) (2) (a)