St Andrew's Healthcare - Adolescents Service

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	Requires improvement
Are services safe?	
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Requires improvement

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.

Summary of findings

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

Overall summary

We rated St Andrews Healthcare Adolescent services as **requires improvement** because:

- Internal doors throughout the building, between wards did not have automatic door closures. Staff had to ensure that all doors were firmly closed behind them, as they sprang open. This could cause a delay if staff were responding to an incident.
- Each ward had only one qualified nurse on duty throughout the night. Therefore nurses were unable to take proper breaks. Use of agency staff at nights had led to permanent staff completing medication administration across different wards, as not all agency staff had the required log in details to the electronic system. Bank and agency staff could not always fill vacancies requested, meaning that wards had to work below establishment numbers.
- Staff had received training in the Mental Capacity Act. However, knowledge was minimal during discussions.
- Staff did not always explain the rights to detained patients in a timely way.
- Qualified staff did not have adequate knowledge around Gillick competence and Fraser guidelines.
- We saw two patients being searched in a communal area by staff, where others could see.
- Patients were unable to access drinks freely and had to ask staff for refreshments.
- Staff did not have an understanding of the vision and the values of the hospital.
- Staff reported that senior staff, above the modern matron level, were not visible on the wards.
- Staff did not keep formal records of supervision. The service could not be sure of the quality of supervision for staff, or be ensured that issues were being followed up appropriately.
- Staff were regularly being moved across the service to cover shortfalls elsewhere, meaning staffing was not adequate.
- Not all senior qualified staff had an understanding of the hospital risk register, how this was reviewed and updated.
- Some staff we spoke with felt excessive pressure was put on them to meet hospital objectives, for example when admitting patients. Ward staff felt undervalued by senior staff throughout the organisation.
- Ward staff did not feel that they were given many opportunities to give feedback or input into service development.

However:

- Staff completed comprehensive assessments of patients in a timely way following admission.
- Patients had a physical health assessment on admission, and on-going monitoring of physical health when needed.
- Patients had access to a wide range of psychological therapies.
- Qualified staff had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles.
- Patients were involved in their care planning and positive behavioural support plans.
- Learning from incidents was cascaded to ward staff.
- Most staff knew of the whistle-blowing process and felt they would raise concerns if necessary. We were told by the provider that the service director and clinical director regularly spent time on the wards. The provider demonstrated that the vision and values of the hospital were discussed at staff induction and during team meetings.
- Each ward had one ward manager, which provided consistency for both staff and patients. There were governance processes in place to monitor quality, performance and take appropriate action following serious incidents. There were weekly manager and matron meetings to review issues, monthly quality and safety meetings which included the managers, clinicians and compliance manager. There were weekly bed management meetings to review bed numbers.

Summary of findings

- Staff felt supported by one another, and felt that there was good team working across the service, to do the best for the patients.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Child and adolescent mental health wards	**Requires improvement** 	Maple ward is a female, low secure ward that can accommodate up to 10 children and adolescents with complex mental health needs. Meadow ward is a female, low secure ward that can accommodate up to 10 children and adolescents with complex mental health needs. Berry is a female ward that can accommodate up to eight children and adolescents who have acute mental health needs. Marsh ward is a male, low secure ward that can accommodate up to 10 child and adolescents with complex mental health needs. Willow ward is a female, low secure ward that can accommodate up to 10 children and adolescents with complex mental health needs. Sycamore is a male ward that can accommodate up to 10 children and adolescents with complex mental health issues. Oak ward was closed at the time of inspection. It is a male ward that can accommodate up to 10 children and adolescents with complex mental health needs. Acorn ward is a male, medium secure ward that can accommodate up to 10 children and adolescents with learning disabilities and autistic spectrum disorder. Fern ward is a female, low secure ward that can accommodate up to 10 children and adolescents with learning disabilities and autistic spectrum disorder. Bracken ward is a male, medium secure ward that can accommodate up to 10 children and adolescents with learning disabilities and autistic spectrum disorder. Brook ward is a male ward that can accommodate up to 10 children and adolescents with learning disabilities and autistic spectrum disorder.

Summary of findings

Contents

Requires improvement

St Andrew's Healthcare

Services we looked at

Child and adolescent mental health wards

Summary of this inspection

Background to St Andrew's Healthcare - Adolescents Service

St Andrew's Healthcare Northampton has been registered with the CQC since 11 April 2011. The services have a registered manager and a controlled drug accountable officer. The registered locations at Northampton are adolescent services, men's services, women's services and acquired brain injury (neuropsychiatry) services.

Northampton is a large site consisting of more than ten buildings, more than 50 wards and has 659 beds.

St Andrew's Healthcare also has services in Nottinghamshire, Birmingham and Essex.

The locations at St Andrew's Healthcare Northampton have been inspected 19 times. The last comprehensive inspection was in June 2016. The CQC identified issues in relation to aspects of care in the effective domain which was rated as requires improvement. We reviewed that domain and the well led domain on this inspection. We identified that improvements were required in physical health monitoring of patients in seclusion and following rapid tranquillisation and the carrying out of searches in communal areas.

We also carried out a focused inspection in February 2017 looking at the use of restraint in learning disabilities services; this included the relevant CAMHS wards. We told the provider to ensure patients in seclusion or segregation had up to date plans in place.

There had been previous visits to the wards by Mental Health Act reviewers. We considered these in preparation for this inspection.

Patients receiving care and treatment at St Andrew's Healthcare follow care pathways. These are women's mental health, men's mental health, autistic spectrum disorder, adolescents, neuropsychiatry and learning disabilities pathways.

The following services were visited within the adolescent services:

Maple ward is a female, low secure ward that can accommodate up to 10 children and adolescents with complex mental health needs.

Meadow ward is a female, low secure ward that can accommodate up to 10 children and adolescents with complex mental health needs.

Berry is a female ward that can accommodate up to eight children and adolescents who have acute mental health needs.

Marsh ward is a male, low secure ward that can accommodate up to 10 child and adolescents with complex mental health needs.

Willow ward is a female, low secure ward that can accommodate up to 10 children and adolescents with complex mental health needs.

Sycamore is a male ward that can accommodate up to 10 children and adolescents with complex mental health issues.

Oak ward was closed at the time of inspection. It is a male ward that can accommodate up to 10 children and adolescents with complex mental health needs.

Acorn ward is a male, medium secure ward that can accommodate up to 10 children and adolescents with learning disabilities and autistic spectrum disorder.

Fern ward is a female, low secure ward that can accommodate up to 10 children and adolescents with learning disabilities and autistic spectrum disorder.

Bracken ward is a male, medium secure ward that can accommodate up to 10 children and adolescents with learning disabilities and autistic spectrum disorder.

Brook ward is a male ward that can accommodate up to 10 children and adolescents with learning disabilities and autistic spectrum disorder.

The child and adolescent services moved into a new building in January 2017 called Fitzroy House, the ward names had changed as part of this move. St Andrew's healthcare offers low and medium secure specialist services for children and adolescents with mild / moderate learning disabilities, autistic spectrum disorder, behaviour that challenges and individuals who may have

Summary of this inspection

a mental health problem and offending history. Fitzroy can accommodate 110 patients in total. At the time of inspection, there was a total of 84 patients receiving care and treatment.

St Andrew's Healthcare offer care and treatment to children and adolescents who may have a neuro-disability. There is a specific service for one individual within the grounds.

The adolescent service is able to offer education opportunities for young people through St Andrew's college. The college is Ofsted registered and rated as outstanding.

This inspection was an announced focused inspection.

Our inspection team

Inspection lead: Margaret Henderson, Inspection Manager, mental health hospitals, CQC

The team that inspected the services included two inspectors and three specialist advisors (all registered nurses). In addition the team were supported by a further two inspectors over two days, and an inspection assistant for one day. Two Mental Health Act Reviewers examined patient records as part of a hospital wide seclusion review. A pharmacist looked at a specific concern identified during the inspection.

The team would like to thank all those who met and spoke to inspectors during the inspection and were open and balanced with the sharing of their experiences and their perceptions of the quality of care and treatment.

Why we carried out this inspection

We undertook this inspection to find out whether St Andrew's Healthcare Northampton had made improvements to their adolescent services, since our last inspection at Northampton in June 2016.

The adolescent wards were rated as good overall, and requires improvement for the effective domain.

Following the June 2016 inspection, we told the provider to take the following actions:

- The provider must follow best practice in relation to people have positive behaviour support plans where appropriate.
- The provider must ensure that staff had an understanding of children's rights.
- The provider must review the risk safety management system, which was not designed for the specific use of children's services and was not person centred.

Following the February 2017 inspection we told the provider to take the following action:

- The provider must ensure that all patients who are being cared for in seclusion or long-term segregation have appropriate care plans in place.

How we carried out this inspection

During this inspection we looked at the effective and the well led domains.

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

During the inspection visit, the inspection team:

- visited all 10 wards at the hospital; looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 19 patients who were using the service
- Spoke with five carers of people who were using the service
- spoke with the managers of each of the wards

Summary of this inspection

- spoke with 57 other staff members; including doctors, nurses, healthcare assistants, occupational therapists, psychologists, physiotherapist, social worker and teacher
- reviewed 34 care and treatment records of patients, and completed case tracking for three of these
- Undertook three periods of observations on three different wards
- Received feedback on five comment cards from family and carers.

Information about St Andrew's Healthcare - Adolescents Service

What people who use the service say

We spoke with 19 patients across the service. Nine patients felt that there was not enough staff on the wards to meet their needs. Six patients gave examples of being unable to utilise leave due to staff shortages.

Patients felt that they had regular and appropriate contact with family members.

Nine patients felt involved with their care planning.

There was a mixed view on the food served. Some felt that the portions were too small, with limited choice. Others felt it was adequate.

Three patients spoke about the dynamics of the ward in terms of other patients being aggressive or intrusive, which they found unsettling.

Carers we spoke with felt that the staff were caring and respectful. They felt able to maintain regular communications with the patients.

Two carers told us about safeguarding concerns involving their relative – and felt that the staff acted on these appropriately.

Three carers felt that communication from the nursing staff in relation to incidents was not always timely.

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?

Following our inspection in June 2016 we rated the service as good for safe. We did not inspect this key question.

However, we found:

- Internal doors within Fitzroy did not have automatic door closures. Staff had to check that these doors were closed properly when going through.
- Staff felt concerned when responding to incidents within the building due to delays in getting through airlocks between wards. Some airlocks were operated by a camera located in the main reception of the building. This could cause a delay in the event of an incident.
- Staff reported that on occasions they have not always had staff to ensure that enhanced observations were covered.
- It was difficult for the nurse on duty at night to take their breaks, as each ward had only one qualified nurse on duty.
- Some wards had to work below established numbers, as additional bank and agency staff could not always cover requested shifts.
- When speaking with a patient, the patient appeared to be over sedated. The pharmacist visited the ward, the patient and examined treatment records, including medication chart. Concerns around the different medications prescribed and levels were escalated to senior management during inspection.The provider explained that the patient had been admitted five days prior to the inspection and was still undergoing assessment and medication review at the time of the inspection
- The Mental Health Act reviewers examined 10 seclusion records. None of which were complete. Seven out of the 10 records did not detail individual clinical needs of patients, how staff managed risks, what clothing and bedding would be provided, and how dietary and fluid needs were to be addressed.

Are services effective?

Requires improvement

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

- Qualified staff had a lack of knowledge around Gillick competence and Fraser guidelines. Staff confirmed that these are not included in any current training offered.

Summary of this inspection

- Staff had received training in the Mental Capacity Act. However, knowledge was poor during discussions.
- Staff did not always explain the rights to detained patients in a timely way following transfer from another hospital or when a section was renewed.

However,

- Staff completed timely and comprehensive assessments following admission.
- Patients had their physical health needs assessed on admission and routinely thereafter.
- Staff undertook a range of clinical audits to monitor the quality of the service.
- Staff received appraisals on a yearly basis.

Are services caring?

Good

Following our inspection in June 2016 we rated the service as good for caring. We did not inspect this key question.

However, we found:

- Staff undertook personal searches of patients who had returned from leave in areas that was visible to others. This inappropriate practice was reported on during the 2016 inspection.

Are services responsive?

Good

Following our inspection in June 2016 we rated the service as good for responsive. We did not inspect this key question.

However, we found:

- Patients did not have free access to water or drinks. There were no water coolers on the wards or in the activity centre. Patients therefore had to rely upon staff to get them drinks at their request.
- There were 13 patients who were 18 years old across the service at the time of inspection. A further 18 patients would turn 18 over the forthcoming six months. The service alerted commissioners and other stakeholders nine months before the patient's 18th birthday. However, the lack of suitable placements meant transfers were delayed. This meant 18 year olds were on CAMHS wards which is not acceptable.

Are services well-led?

Requires improvement

We rated well led as **requires improvement** because:

Summary of this inspection

- Staff did not have a clear understanding of the vision and the values of the hospital.
- Staff we spoke with told us that senior managers above the modern matron were not visible on the wards.
- Staff received regular supervision. However, this was not formally recorded and so the service could not effectively monitor the quality of this.
- Staff we spoke with felt excessive pressure was put on them to meet hospital objectives, for example when admitting patients.
- Staff at ward level did not feel that they had much opportunity to contribute to discussions about the service or service development.

However:

- The provider demonstrated that the vision and values of the hospital were discussed at staff induction and during team meetings. We were told by the provider that the service director and clinical director regularly spent time on the wards.
- Staff received mandatory training and scheduled updates. All staff received an annual appraisal.
- Learning from incidents was shared across the service and cascaded to ward level.
- Ward managers had many opportunities to contribute to discussions around service development.
- Teams on the wards felt supported by their colleagues and peers, and felt that they all worked together to do the best they could for the patients.
- There were governance processes in place to monitor quality, performance and take appropriate action following serious incidents. There were weekly manager and matron meetings to review issues, monthly quality and safety meetings which included the managers, clinicians and compliance manager. There were weekly bed management meetings to review bed numbers. There was a restrictive practice monitoring group looking at reducing restrictive practice.

Detailed findings from this inspection

Mental Health Act responsibilities

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

- Mental Health Act paperwork was examined by staff who were familiar with detention papers.
- Qualified staff were sent reminders via email with regards to appeals against detention, dates for report submissions, and dates for explaining rights to patients.
- Clear records of leave granted were kept. The multidisciplinary team reviewed these regularly. Patients were able to have copies if they wished.
- Training in the Mental Health Act was mandatory for staff, overall, 88% of staff had completed this. Qualified staff had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles.
- Consent to treatment and capacity requirements were adhered to. Copies of consent to treatment forms were stored electronically and also in paper form in the clinic room on each ward.
- Nursing staff did not always explain rights to detained patients in a timely way.
- Seclusion records examined across the service were incomplete.

Mental Capacity Act and Deprivation of Liberty Safeguards

- The service reported that 88% of staff had received training in the Mental Capacity Act, which was mandatory. However, staff knowledge on this was poor during interviews. A small number of qualified staff were able to explain the purpose of the Act and guiding principles. Other staff both qualified and unqualified were not able to describe the purpose of the Act, or what age range this applied to. When staff relayed the content of the training, many referred to the Mental Health Act and not the Mental Capacity Act. This demonstrated a lack of understanding.
- Staff explained that if they had any concerns around aspects of a patient's capacity in terms of care and treatment, the multi-disciplinary team would discuss. We saw evidence of this in patient care records.
- Staff knew they could approach the Mental Health Act administrator or other colleagues for advice around the Mental Capacity Act if needed.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Child and adolescent mental health wards	N/A	Requires improvement	Good	Good	Requires improvement	Requires improvement
Overall	N/A	Requires improvement	Good	Good	Requires improvement	Requires improvement

Requires improvement

Child and adolescent mental health wards

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

Are child and adolescent mental health wards safe?

Following our inspection in June 2016 we rated the service as good for safe. We did not inspect this key question.

However, we found:

Safe and clean environment

- Internal doors around the building did not have automatic door closures. This was in line with hospital policy and had been appropriately risk assessed. However, we saw that staff had to check these doors were firmly closed when going through. If the staff did not ensure the doors were closed properly, they sprang back open. This could be problematic if a staff member was in a hurry to get to another ward. One staff member had sustained a serious injury to a finger.
- Staff told us they felt concerned when responding to incidents within the building due to delays in getting through the airlocks between wards. A camera located in the main reception of the building operated some airlocks. This could cause a delay in the event of an incident. However, the provider assured us that the airlock arrangements were in line with medium secure guidelines.

Safe staffing

- Staff reported that on occasions they have not always had staff to ensure that enhanced observations were covered. Duty rotas examined showed that there was enough staff to cover enhanced observations. However, if wards had high observation levels, there were occasions when a ward would have one or two staff members only in the main ward area. This could prove challenging for staff to meet patient's needs.
- Each ward reported that they only had one qualified nurse on duty throughout the night. It was difficult for the nurse to get a break, as they could not leave the ward unless there was a qualified member of staff providing cover.
- Agency staff were used on some wards, both qualified and healthcare assistants. While managers tried to book staff that were familiar with the wards, this was not always possible. We learned of one incident when an agency nurse could not direct a staff team with a patient under restraint to seclusion, as they did not know where the seclusion room was.
- Agency staff were not always given log in details for the electronic prescribing system. Therefore, if in charge of a ward they could not administer medication to patients. A permanent staff member from another ward would have to complete. We learnt that on one occasion, a nurse had to complete three medication rounds across different wards. This resulted in a medication error where a patient was given another patients medication. This was reported and managed effectively. On occasions whereby permanent staff have had to undertake several medication administrations, this resulted in a number of patients receiving their prescribed medications late.
- Each ward reported sufficient staffing if they were able to utilise bank or agency staff for enhanced observations. Additional staff were requested by ward manager's dependent on need. However, staff reported that not all shifts were covered by bank or agency staff

on all wards, leaving them below establishment numbers. Staff were often required to work across different wards, meaning that some wards were left short staffed.

- Data provided from the hospital showed that across the service, there were 25 nurse vacancies, and 40 healthcare assistant vacancies during inspection. However, follow up data received showed that the hospital had recruited into all vacant healthcare assistant posts, and had recruited two posts over establishment numbers.
- The hospital requested bank and agency staff, however not all shifts were filled. In February 2017, the hospital were unable to cover 23% of requested shifts with agency staff; in March there were 23% of requested shifts unfilled, and in April 19%. This could impact upon meeting patient's needs, for example utilising escorted leave.
- Between the 22 January 2017 and the beginning of May, duty rota's showed there had been 116 shifts with only one nurse on duty throughout the day across the service. There was a further 44 shifts where nurses had worked for parts of the shift as the only nurse.

Assessing and managing risk to patients and staff

- When speaking with a patient, the patient appeared to be over sedated. The pharmacist visited the ward, the patient and examined treatment records, including medication chart. Concerns around the different medications prescribed and levels were escalated to senior management during inspection. The provider explained that the patient had been admitted five days prior to the inspection and was still undergoing assessment and medication review at the time of the inspection.

Are child and adolescent mental health wards effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- We examined 34 care records. Staff completed comprehensive and timely assessments of patients following admission.
- Patients had a comprehensive physical health assessment upon admission, with on-going monitoring of physical health problems when needed. The initial examination identified any other services which were required, such as dentistry, podiatry, and opticians.
- Care plans were personalised, holistic and recovery focused. Staff updated these regularly. Each patient had a comprehensive positive behavioural support plan stored electronically. In addition to this, each ward held paper copies of positive behavioural plans "at a glance". These were shortened plans containing details around each patient, which staff could pick up and read. This would be particularly helpful if staff were unfamiliar with patients. Staff and patients put individual plans together to accurately reflect needs, and how best to engage with the patient.
- Care records were stored electronically. They were available to view by staff if a patient moved within the service. Some documents, such as physical health observations, and supported observations were hand written and later scanned onto the system by administrative staff.

Best practice in treatment and care

- Patients had access to different psychological therapies such as dialectical behaviour therapy, sex offender work, anxiety management, living with psychosis, anger management and cognitive behavioural therapy.
- Patients had access to physical healthcare when needed. Doctors could attend the wards at short notice to assess patients' health. Staff worked with other healthcare professionals on a referral basis, including general practitioners, practice nurse, speech and language therapist and physiotherapists. The child and adolescent service had two associate nurse practitioners, five nurse practitioners and four physical healthcare assistants. These staff assisted ward staff to ensure that patients were able to attend follow up appointments for both routine and emergency care.
- Staff used recognised rating scales to assess and record treatment outcomes. One example of which was the health of the nation outcomes scale.
- Staff undertook clinical audits including hand washing, infection control, care planning and medication audits.

Skilled staff to deliver care

Requires improvement

Child and adolescent mental health wards

- There was a range of mental health disciplines working across the service. This included consultant psychiatrists, associate specialists, nurses, psychologists, occupational therapist, social workers, teachers and healthcare assistants.
- Staff had varied experience and qualifications. Many healthcare assistants had previously undertaken NVQ qualifications in health and social care. New healthcare assistants were required to complete a course in conjunction with a local university, which consisted of several modules around health and social care. Healthcare assistants could then progress to the 'Aspire' programme, which is a degree in nursing. Some nurses had been supported to undertake further accredited study around the care and treatment of children and adolescents. Staff with professional qualifications were supported with continual professional development.
- All staff received an induction to the service. This included a one-week hospital wide induction which covered various training such as safety and security, basic life support and the management of actual and potential aggression (MAPA). Each staff member then had some time on their allocated ward, on a supernumerary basis. This enabled them to become familiar with the ward environment and the patients.
- Ward managers held regular team meetings. Supervision was available on a one to one basis, as well as within groups. The service reported that the clinical supervision target was 85%. All of the wards within this service had achieved over 97% compliance. Staff received both clinical and management supervision. However, records of discussions were not kept consistently by the supervisor or the supervisee.
- Staff received annual appraisals. The appraisal target rate across this service was 75%. At the time of inspection appraisal rates were reported to be 100%.
- Staff received training that was appropriate for their roles. However, there was no training, which covered Gillick competence. Gillick competence is the principle used to judge capacity in children to consent to treatment. Fraser guidelines refer more specifically to contraceptive advice, and looks at children under 16 being competent to receive such advice without parental knowledge or consent. Staff knowledge around this was minimal. Some staff interviewed were able to give a brief description of what these were, but most could not. Staff told us that they had been told to read up about these, but had not had time to do so.
- Poor staff performance was addressed promptly and effectively managed by senior staff with advice from human resources where appropriate.

Multi-disciplinary and inter-agency work

- Wards held weekly multi-disciplinary meetings. Each patient received a comprehensive review every two weeks. This involved reviewing risk and care plans. Patients were able to put in requests to the team weekly so that they did not have to wait two weeks for decisions around care, such as having leave.
- Each ward had a hand-over period of 15 minutes. Staff generally felt that this time was adequate to relay information to oncoming staff. If the wards had been busy then staff extended the time to ensure all information was relayed. The wards relied on the good will of staff to remain on shift to facilitate this.
- Nursing staff maintained communications with care co-ordinators and updated other professionals as and when necessary.

Adherence to the MHA Code of Practice

- Mental Health Act paperwork was examined by staff that were familiar with detention papers.
- Staff knew who the supporting Mental Health Act administrators were and how to contact them. Qualified staff were sent reminders via email with regards to appeals against detention, dates for report submissions and dates for explaining rights to patients. Staff contacted administrators if advice around the Mental Health Act was needed.
- Clear records of leave granted were kept. The multidisciplinary team reviewed these regularly. Patients were able to have copies if they wished.
- The service reported that 88% of staff had received training in the Mental Health Act, which was mandatory. Qualified staff had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles.
- Consent to treatment and capacity requirements were adhered to. Copies of consent to treatment forms were stored electronically and also in paper form in the clinic room on each ward.

Requires improvement

Child and adolescent mental health wards

- We found several examples of staff not explaining rights to detained patients in a timely way on the learning disability wards. On one ward, we found that staff had not explained rights to a detained patient for a seven-month period. This did not meet the service target of revisiting rights every six months. On another ward, a patient had been detained prior to transfer, in October 2016. Staff did not explain their rights for two weeks after admission. It is good practice to explain rights with patients upon transfer from one hospital to another. A further example involved a patient detained in May 2016. Staff had explained rights following the detention on the 04/05/2017, and then again on the 16/05/2016 as the patient did not appear to understand. The patient still did not understand, yet staff did not discuss this again with the patient until 24/06/2017.
- Detention paperwork was completed, up to date and stored securely.
- Patients had access to advocacy services. Visible posters were on the wards and staff explained the process to patients.

Good practice in applying the MCA

- The service reported that 88% of staff had received training in the Mental Capacity Act, which was mandatory. However, staff knowledge on this was poor during interviews. A small number of qualified staff were able to explain the purpose of the Act and guiding principles. Other staff both qualified and unqualified were not able to describe the purpose of the Act, or what age range this applied to. When staff relayed the content of the training, many referred to the Mental Health Act and not the Mental Capacity Act. This demonstrated a lack of understanding.
- At the time of inspection there were no patients under Deprivation of Liberty safeguards. No recent applications had been reported.
- Staff were aware of where to locate the hospital policy on the Mental Capacity Act and the Deprivation of Liberty safeguards.
- Staff explained that if they had any concerns around aspects of a patient's capacity in terms of care and treatment, this would be discussed during the weekly multi-disciplinary meetings. We saw evidence of this in patient care records.
- Staff knew they could approach the Mental Health Act administrator or other colleagues for advice around the Mental Capacity Act if needed.

Are child and adolescent mental health wards caring?

Good

Following our inspection in June 2016 we rated the service as good for caring. We did not inspect this domain.

However we found:

Kindness, dignity, respect and support

• We saw two patients being searched outside of the nursing office on two different mental health wards. This was not completed in a private or dignified way, despite the wards having different rooms where this could have been completed away from others.

• We observed some kind and effective interactions between staff and patients throughout the inspection.

The involvement of people in the care they receive

• Patients were involved with care planning and staff offered a copy of care plans.

Are child and adolescent mental health wards responsive to people's needs? (for example, to feedback?)

Good

Following our inspection in June 2016 we rated the service as good for responsive. We did not inspect this domain.

However, we found:

The facilities promote recovery, comfort, dignity and confidentiality

- Patients did not have unrestricted access to water or drinks. There were no water coolers on the wards or in the activity centre. Patients therefore had to rely upon staff to get them drinks at their request. On one ward the staff had prepared drinks for patients and left them in the kitchen, meaning that patients still had to ask for these.

Access and discharge

Requires improvement

Child and adolescent mental health wards

- Within the service, there were 13 of patients who were aged 18. A further 18 patients would turn 18 over the following six months.
- Staff attempted to transition patients into adult services in a timely manner. However, the process of identifying a suitable placement to meet the needs of the patients could be difficult. For patients who had turned 18, appropriate care plans and risk assessments were in place which highlighted any safeguarding concerns in relation to an adult being cared for on an adolescent ward. The service alerted commissioners and other stakeholders nine months before the patient's 18th birthday. However, the lack of suitable placements meant transfers were delayed. This meant 18 year olds were on CAMHS wards which is not acceptable.

Are child and adolescent mental health wards well-led?

Requires improvement

Vision and values

- The vision of St Andrews healthcare was "transforming lives by building world-class mental healthcare services". They had four core values, compassion, accountability, respect and excellence. Staff did not have a clear understanding of the vision and the values of the hospital. Staff interviewed gave us different accounts of what they believed these to be.However, most staff said that part of the values was around providing good care.The provider demonstrated that the vision and values of the hospital were discussed at staff induction and during team meetings.
- Staff knew who the senior managers in the organisation were. Ward based staff told us the modern matron was highly visible, and had seen the service director on the wards on occasions. Staff reported that management that was more senior were rarely on the wards. However, we were told by the provider that the service director and clinical director regularly spent time on the wards.

Good governance

- Staff received mandatory training and scheduled updates. However, staff reported that although training was often scheduled, they could not always attend if they were on the wards due to being busy. Some staff explained that they were expected to attend and complete training on their scheduled days off. Staff were paid to undertake training if they attended on their scheduled days off.
- Staff received annual appraisals which were conducted at a set time of the year.
- There was no consistent regular line management supervision in place. Clinical supervision was in place, but the quality of this was not monitored. The supervisor and the supervisee signed a form to confirm that one to one supervision had taken place. In addition to this, ward managers held regular team meetings, some of which they classed as supervision. Psychology staff held formulation meetings to discuss individual patients, which staff were invited to attend. This was recorded as group supervision. Staff reported that the supervision was a mixture of clinical and management, and occurred on more of an 'ad hoc' basis, depending on the business of the wards. However, staff did not keep formal records of the content of supervision. Therefore, the service could not be sure of the content and quality of supervision for staff.
- Staff reported incidents in accordance with hospital policy and referred to these in day to day care records.
- Learning from incidents was shared through team meetings, via email and in regular meetings attended by ward managers. Ward managers would be responsible for ensuring that these were discussed at ward level and appropriate learning implemented.
- Ward managers had set key performance indicators which enabled them to monitor the performance of their team. Examples of this given were training and supervision percentages for staff. Ward managers accessed regular statistics, which enabled them to follow up with staff where deficits were highlighted.
- Ward managers felt that they had sufficient authority and administrative support that helped them in their role.
- Most ward managers had knowledge of the hospital risk register, how this was monitored, reviewed and updated.

Leadership, morale and staff engagement

- At the time of inspection, ward managers reported there were seven staff members who had been off on

long-term sickness. Sickness was considered to be long term if the absence was for more than four weeks. Of the seven, one was due to work stress, and one related to an injury sustained at work.

- At the time of inspection there were no reported bullying or harassment cases ongoing. A number of staff across all disciplines told us that clinical decisions around admissions had been over-ridden by senior managers. This led to patients being inappropriately admitted to the service.
- Most staff we spoke with were aware of, and knew how to use the whistle-blowing policy. Staff confirmed that they felt they could raise concerns without fear of victimisation. However, a small number of staff told us that while they would raise concerns if in the best interests of the patients, they were unsure how they would be treated subsequently.
- Each ward had one allocated ward manager. Previously one ward manager covered two wards. Managers we spoke with were pleased about this and felt that they had more time to be role models, and provide more support for staff. One ward manager per ward had been in place since March 2017. Staff reported on each ward, that due to the changes within the organisation, they had all worked with several different ward managers over the past twelve months. Although staff reported that this had been difficult, all were pleased that each ward had one manager and hoped that this would give some stability and consistency for the staff and the patients.
- Staff at ward level felt supported and appreciated by their ward managers. However, staff felt undervalued by more senior staff within the organisation. The provider sent information which demonstrated visits by senior management. Gratitude was also expressed to staff through the CARE award.
- Senior staff had opportunities for leadership development. Ward managers and clinical team leaders were encouraged to attend this training to enhance skills.
- Ward staff felt supported by colleagues and felt that they worked together well as part of a team.
- Staff were open and transparent with patients if things went wrong. For example staff gave us examples of when escorted leave had to be postponed, and they explained to patients and tried to re-schedule. Another example given was in respect of a medication error. Staff had informed the patient and followed hospital policy.
- Ward managers felt they had the opportunity to give feedback on services and input into service development. Some were involved with the new building and the transition. In addition to this, ward managers attended numerous meetings whereby they could contribute to discussions around the service. In contrast to this, staff on the ward did not feel that they were given much opportunity to give feedback or input into service development.

Commitment to quality improvement and innovation

- The service takes part in the quality network for inpatient child and adolescent mental health (QNIC). The last report was dated December 2015.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that staff have a good working knowledge of the Mental Capacity Act and the guiding principles.
- The provider must ensure that qualified staff understand Gillick competence and Fraser guidelines.
- The provider must ensure that patients have access to cold drinks throughout the 24 hour period.
- The provider must ensure that there are adequate numbers and skill mix of staff on the wards to meet the needs of the patients.
- The provider must review how supervision is recorded and securely stored as per hospital policy.

Action the provider SHOULD take to improve

- The provider should consider undertaking a review regarding the internal doors.
- The provider should ensure that staff explain rights to detained patients in a timely manner.
- The provider should ensure that staff conduct patient searches in private areas.

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 11 HSCA (RA) Regulations 2014 Need for consent • Staff did not have a good working knowledge of the Mental Capacity Act; Gillick competence and Fraser guidelines. This was a breach of regulation 11

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 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs • Patients did not have free access to drinks, and had to request these from staff. This was a breach of regulation 14

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 • Wards only had one qualified staff member throughout the night on each ward, and so it was difficult for staff to take breaks. • Wards worked under establishment numbers as not all shifts could be covered by bank and agency staff. This impacted upon patient care. • There was not robust supervision plans in place. Management supervision was undertaken through the annual appraisal process. No records were kept of clinical supervision. There could not be assurance that staff were monitored and supported appropriately. This was a breach of regulation 18