

Good

5 Boroughs Partnership NHS Foundation Trust

Child and adolescent mental health wards

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RTVX1	Fairhaven	Fairhaven Young People's Unit	WA2 9TN

This report describes our judgement of the quality of care provided within this core service by 5 Boroughs Partnership NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by 5 Boroughs Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of 5 Boroughs Partnership NHS Foundation Trust.

Summary of findings

Ratings

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

Overall rating for the service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Good 

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

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

- Staff delivered person centred care in a kind and respectful way.
- Staff completed care programme approach patient assessments and reviews in a timely manner.
- Patients and carers told us they were involved as partners in care.
- Patients told us they were satisfied with the care they received and felt supported.
- Patients had current care plans and risk assessments.
- Care plans were recovery and outcome focussed.
- Patients had a physical health assessment on admission to the ward.
- The ward staff worked effectively as a team with professionals from various backgrounds.
- Staff showed a clear understanding of the Mental Health Act 1983 and issues relating to the capacity of young people to make decisions about their care.

- Patients and carers told us that staff treated them with kindness, dignity and respect.
- Staff told us they felt supported and they could raise concerns without fear of recriminations.
- There was a training plan in place and good development opportunities.
- The team reported incidents of harm and risk of harm and had a clear system to share learning.
- Staff told us they were happy and felt valued as team members.
- Local leadership was available to staff and supportive of role development.

However, not all prescription charts for 'as required' medication had been reviewed within the last 14 days in line with current guidance. Patients did not have access to a female-only lounge on the ward.

Summary of findings

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

Are services safe?

We rated safe as good because:

- The ward area was visibly clean and well maintained.
- The trust was recruiting to the vacancies and the ward manager was managing the other absences.
- The service contained a mix of staff from different professions and grades.
- The ward manager had the authority to adjust staffing levels to meet patient need.
- Staff were encouraged to report all incidents, so that learning could occur.
- Staff had a good understanding of the safeguarding procedures and systems to learn lessons when things go wrong.
- All bedrooms were en-suite and there were separate toilets for males and females.
- All patients had a physical health examination completed on admission to the ward. We saw that physical health was regularly monitored and reviewed.
- Patient records were complete, accessible and in a format that was easy to understand.
- The ward clinic room had emergency equipment and this was checked at regular intervals.

However, not all prescription charts for 'as required' medication had been reviewed within the last 14 days in line with current guidance. Patients did not have access to a female-only lounge on the ward.

Good



Are services effective?

We rated effective as good because:

- Patients' needs were assessed at the point of admission and regularly reviewed. Discharge planning was considered throughout the admission.
- Care Programme Approach meetings, where people connected to the care and support of the patient came together to discuss progress and future options for support, were scheduled and occurred throughout the patient's admission. Patient outcomes were assessed on an on-going basis using recognised tools.
- Staff had good opportunities for learning and development and demonstrated a good practical understanding of the Mental Health Act 1983 (MHA) and issues for young people's capacity to make decisions about their care.
- The team carried out regular audits to improve the quality of their records.

Good



Summary of findings

- Risk assessments were completed on individual patients in order to keep patients and staff safe.
- A range of psychological therapies were available to the patients. Staff were completing further training to enhance the opportunities for patients.
- The patient records were both outcome and recovery focused and showed clear involvement of the patients.
- The prescription records were within expected and recognised prescribing guidance.
- The patients were offered a minimum of 24 hours' education a week during term time.

However, community care co-ordinators were not always present at patient reviews, which meant that communication and information sharing was not as effective as it could have been.

Are services caring?

We rated caring as good because:

- The patients told us and we observed that the staff were respectful, courteous and supportive.
- Patients told us that their admission to Fairhaven had been a positive experience.
- Staff understood the individual needs of patients.
- Patients were involved in decisions about their care and the development of their plans of care.

Good



Are services responsive to people's needs?

We rated responsive as good because:

- The ward had a good range of rooms and outdoor space to meet patients' needs.
- The patients had access to hot and cold drinks and snacks 24 hours a day.
- There was a weekly activity programme that occurred over all seven days.
- Patients had asked for more activities off the ward and this had been listened to and acted on so that each day an activity took place off the ward.
- The ward was accessible to people with disabilities, including wheel chair users.
- Staff knew how to deal with and report complaints.

However, the only leaflets that were displayed were in English. Sometimes discharges were delayed due to low numbers of suitable placements.

Good



Summary of findings

Are services well-led?

We rated well-led as good because:

- Staff knew the vision and values of the trust; senior staff could explain how these were incorporated into the ward activity.
- The staff team knew who senior managers were.
- One senior manager visited the ward weekly to carry out an activity with patients.
- The ward had effective systems for monitoring and managing mandatory training.
- The staff reported that they were happy in their roles and the ward worked together as one team.
- The ward was involved in a national audit that demonstrated the staff's commitment to continual improvement.

Good



Summary of findings

Information about the service

5 Boroughs Partnership NHS Foundation Trust provides child and adolescent in-patient mental health services at Fairhaven young people's unit in Warrington.

Fairhaven has 10 beds and provides in-patient mental health care, support and treatment for children and young people up to the age of 18 years.

Fairhaven young people's unit was last inspected on 21 January 2014. There were no compliance actions taken at that time.

Our inspection team

Our inspection team was led by:

Chair: Kevin Cleary, medical director and director for quality and performance, East London NHS Foundation Trust

Head of Inspection – Nicholas Smith, Care Quality Commission

Team leaders: Sarah Dunnett, inspection manager, Care Quality Commission

Patti Boden, inspection manager, Care Quality Commission

The team that inspected the child and adolescent in-patient mental health services consisted of seven people:

- two CQC inspectors and a range of specialists including:
- a consultant psychiatrist,
- two psychologists,
- nurse
- and an expert by experience (someone who has experience of child and adolescent mental health services).

Why we carried out this inspection

We inspected this core service as part of our on-going comprehensive mental health inspection programme.

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- Visited the in-patient ward, looked at the quality of the ward environment and observed how staff were caring for patients.
- Spoke with eight patients.
- Spoke with two family members.
- Spoke with the ward manager, two deputy managers and the modern matron.
- Spoke with five nurses of various grades.
- Spoke with a nine other staff including; doctors, a teacher, a social worker, teaching assistant, a psychologist, a social work student, ancillary staff and a medical secretary.
- Looked at 10 medication records.

Summary of findings

- Looked at six care records.
- Looked at the clinic room, emergency equipment and ward facilities. Carried out a check of medicines management.
- Looked at a range of policies, procedure and other documents relevant to the running of the ward.
- Observed interactions between patients and staff.
- Attended one ward multi-disciplinary team (MDT) meeting.
- Observed one staff reflective practice session.
- Observed two patient activities –a reading group and a weekly group meeting.
- Attended two care programme approach (CPA) meetings and one patient review.

What people who use the provider's services say

Patients and carers told us they were satisfied with the care and treatment they received from the service. They told us that staff listened to them, offered them support and treated them with kindness, respect and dignity. We were told that the service had given them a chance to talk their issues through and look at ways they could improve their outlook. Patients told us they knew how to make a complaint and felt confident that if they did complain it would be taken seriously.

We were told that the food in the ward was good and nice. Patients told us there was access to both hot and cold drinks throughout the day. They told us about the weekly weekend brunch where they chose, shopped for, and prepared their own food and how they enjoyed this. Patients also told us they enjoyed other activities offered. A carer told us that meetings always went well.

Good practice

The teaching staff had developed a “dragons den” forum at which patients could bid for money for projects. The initial amount of money allocated was £50. Projects included making cakes, cards, candles, and chocolate. The patients were involved in planning, making and selling the produce and they had successfully turned the

initial investment of £50 into £250. The patients were planning to use the profit for additional social activities over the summer holidays. Each week a senior manager attended the unit to run a reading group. This meant that the ward team and patients were connected to the senior management team.

5 Boroughs Partnership NHS Foundation Trust

Child and adolescent mental health wards

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Fairhaven Young People's Unit	Fairhaven

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.

The ward team completed annual Mental Health Act (MHA) e-learning. The ward manager informed us that all staff were either up to date or booked to complete this training. The medical staff team had received a one day update on the revised MHA Code of Practice. The three senior ward staff that we spoke with had a good understanding of their obligations in relation to the MHA.

Three patients were subject to the MHA at the time of our visit. All three patients had consent to treatment forms with their medicine cards, this meant that staff had discussed their medication with them and explained why they were taking it. The patients had agreed to take their medication.

We were told that patients routinely had their rights read to them; daily for Section 2 MHA and monthly for Section 3 MHA. (Patients on Section 2 or 3 of the MHA had been legally detained so that they could receive treatment). Staff

documented this in the patients' care plans. On the notice boards we noted that there were leaflets explaining rights under Section 3 of the MHA; the format was user friendly and age appropriate. There were no leaflets for Section 2 MHA. When asked about the lack of Section 2 leaflets we were informed that staff replaced them regularly but they kept disappearing.

The ward routinely audited all detention paperwork at least every 2 weeks.

The trust had a central team that acted as co-ordinators for the MHA and a source of advice. Staff members knew about this team and stated they would contact them for advice if they were unsure about a patients section papers or if they were having a tribunal to challenge their section.

The ward had a regular specialist independent mental health advocate (IMHA) for young people who visited the

Detailed findings

ward weekly. If there was a request from a patient, the IMHA would attend ward rounds. Requests for IMHAs could be made either via e-mail or telephone. We saw leaflets on the notice boards advising of this service.

Mental Capacity Act and Deprivation of Liberty Safeguards

- The Mental Capacity Act (MCA) act does not apply to young people aged 16 or under. For children under the age of 16, the young person's decision making ability is governed by Gillick competence. The concept of Gillick competence recognises that some children may have sufficient maturity to make some decisions for themselves. The staff we spoke to were conversant with the principles of Gillick and used this to include the patients where possible in the decision making regarding their care.
- Ward staff completed training in MCA via e-learning.
- There were no deprivation of liberty applications made in the previous 6 months.
- Staff were aware of the five principles of the MCA and applied them in their work. Staff were aware of the existence of a mental capacity policy. Staff told us they could refer or consult with the team social worker if needed.

Are services safe?

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

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Safe and clean environment

The environment was clean and tidy and the furniture was in good repair. The cleaning records for the ward showed that the domestic input into the ward was ranging between 93-96% for the past three months which meant that the ward was kept clean. On a recent PLACE audit the ward scored 100% for cleanliness. We saw that the temperature of the fridges in the kitchens and clinic rooms were checked and recorded daily ensuring that food and medicines were kept at a safe temperature.

All bedrooms were individual and had en-suite facilities. There were separate toilet facilities on the ward for male and female patients. Patients could mix together in the communal areas if they wished. Staff informed us there was no designated female only lounge, but that there were quiet rooms that females only could access. The dedicated female only lounge had been lost when the unit had been extended to increase the number of bedrooms to ten.

Assessments of ligature points were carried out by staff. Ligature points are places to which patients intent on self-harm might tie something to strangle themselves. There was one identified ligature point; this was recorded on the environmental risk assessment and staff were instructed how to manage the risk. The circular layout of the ward made it difficult to observe all areas. The staff were aware of this and mitigated this risk through observing patients away from the main day area. We saw this whilst visiting the ward. All patients were on a minimum of 30 minute observation checks; this kept patients safe.

The clinic room contained a couch and emergency equipment. The records we reviewed showed that this equipment was checked regularly every week with no omissions in the previous six months. Medications were audited on a weekly basis by a senior member of staff. We saw that this audit had been carried out without gaps or omissions in the previous six months. This meant that the medication was stored securely and managed safely.

The seclusion room was away from the main ward area, had clear observations, private toilet facilities and a visible clock. Staff carried personal alarms and we heard these whilst we were visiting the ward.

Safe staffing

The ward manager reported that they had sufficient authority to bring in extra staff if needed and also felt confident to raise issues with the Trust which they felt needed addressing.

The ward had an agreed staffing level and skill mix; this was determined at trust level. The ward operated on two qualified staff per shift and three nursing assistants during day shifts and one qualified and three nursing assistants at night. The duty sheets that we checked for the past three months confirmed the required staffing levels had been provided. This meant that there were enough staff to safely support the patients. The ward manager was able to increase the staffing levels on the ward if patients needed extra support due to their illness.

Of the ward staff team six qualified nurses had completed 85% or more of their mandatory training. Three newly qualified nurses who had recently started work were below the trust's target of 85% but we saw that these staff were booked on to complete the training. This meant that staff were trained to carry out their roles.

The ward manager had authority to bring in extra staff to meet patient need and showed us the system for this. The ward used regular bank staff who were already employed by the trust. Regular staff, including bank staff received control and restraint training which meant that staff were appropriately trained.

All qualified nurses completed level three safeguarding training and nursing assistants completed level two safeguarding training. This training was provided by a local authority. The ward social worker was the team lead for safeguarding. Staff members told us if they were unsure they would speak to the social worker for advice. This meant that patients were protected from harm because staff understood what might constitute abuse and how to deal with it.

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The ward had one current vacancy for an activities co-ordinator. Two staff members told us they felt that this impacted on the activities available. An appointment was made to this post on the day of our inspection.

Five staff were absent long term due to either maternity leave or sickness. The manager informed us that the long term sickness was actively managed with the support of the human resources team. Although there was no allocated cover for maternity leave, the ward manager told us they were able to fill these shifts with bank staff members. The ward manager was piloting a system so that when bank staff were required they would work alongside a regular ward team member. This initiative was intended to enhance continuity and the patient experience.

There was no receptionist. This post had been filled but the staff member had not yet started. Three staff members informed us that the receptionist role was currently covered by the ward team. One said this negatively impacted on the ward providing activities; however, other staff appreciated it when they spent time in the office as this gave them dedicated time to make sure their paper work was up to date.

Assessing and managing risk to patients and staff

Six care records were reviewed; each record had a risk assessment present which was completed as part of the admission process. This meant that risks were effectively managed.

There had been 11 incidents of seclusion in the previous six months. There had been no incidents of seclusion or rapid tranquilisation in the past three months. Seclusion is the supervised confinement of a patient in a room, which may be locked. Its sole aim is to contain severely disturbed behaviour likely to cause harm to others. Records reviewed demonstrated 15 minute checks by an observing nurse, 30 minute checks by the nurse in charge, two hourly checks by two registered nurses and a four hourly medical review that included being seen by a doctor. This ensured that secluded patients were regularly reviewed and not secluded for longer than was necessary, in accordance with the Mental Health Act 1983 code of practice.

There were no incidents of long term segregation in the previous six months. Segregation is where a patient is supported in an area away from the main ward and is provided when a patient finds the ward environment stressful and detrimental to their own recovery.

Information provided by the trust informed us that there had been 128 incidents of restraint in the previous six months at Fairhaven. There were 15 instances of prone restraint and 14 instances of using rapid tranquilisation. Staff told us the ward was particularly unsettled between December 2014 and February 2015 and that three service users had accounted for a large number of these incidents. We saw records to confirm this. Staff reported that Fairhaven had managed a complex individual for a 10 day period whilst waiting for a psychiatric intensive care unit bed to become available.

Bedrooms were kept locked during the day; we observed patients asking for access to their bedrooms which was facilitated immediately. We were told that the locked bedrooms were to encourage the patients to attend education and activity sessions and to have a normal day-time regime.

We were told that informal patients could leave at will although the entrance door was locked. There was clear signage by the door advising patients that they should speak to a nurse should they wish to leave.

The care records examined all had a physical health examination, completed on admission. At the handover that we attended, physical health issues were discussed and planning occurred relating to patient need. This meant that patients' physical health was assessed, reviewed and monitored.

All ward records were currently paper based; we observed the records to be kept securely in the ward nurses' office. The multi-disciplinary notes were accessible to all professionals and kept in a chronological order and complete.

All staff spoke confidently about how and when to make a safeguarding referral. They explained recent examples of referrals that they had made and told us about their progress and outcomes. We were shown the electronic system that all staff had access to for reporting safeguarding concerns. A recent example had led to joint training being provided for patients and staff by a specialist police unit in relation to terrorism.

Track record on safety

There had been one serious untoward incident at Fairhaven in the previous 12 months. This incident related

Are services safe?

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to an under 16 year old being admitted to an adult ward. The ward team explained why this had happened and confirmed that whilst on the adult ward the young person had continued to receive regular input from the service.

In the previous six months, the ward had reported 30 other incidents. Of these 17 were classified as non-physical incidents and one was a security breach. Of the remainder five were physical and seven were patient related. Staff told us that following incidents they and the patient involved received a debrief of the situation. Records seen confirmed this.

Reporting incidents and learning from when things go wrong

We saw evidence of how the team were informed of incidents relevant to the children and adolescent mental health services service and wider trust through team meeting minutes. The process of dissemination was described to us by both ward and senior staff members; this meant that the team were informed and lessons could be learnt.

Team meetings were used to update staff regarding any safety updates, issues or learning. We saw evidence to confirm this happened.

Staff knew how to report any incidents that occurred. We were told that the ward team encouraged a culture of reporting all incidents regardless of severity, to make sure nothing was missed. This meant any trends could be identified. An example of this is when staff gave an incorrect dose of an over the counter medicine. Staff told us they apologised to patients and/or their carers if they made a mistake. This meant they understood the duty of

candour. We saw evidence that during a CPA meeting, a carer pointed out that the previous paperwork was inaccurate; this was acknowledged, an apology given and an assurance that it would be corrected.

Staff were informed of incidents within the wider trust that were then shared with the ward team via the monthly team meeting. We saw how practice had changed in response to feedback. We saw that clarification was needed relating to staff's expectations in relation to observation levels. This was documented in the team meeting minutes and we saw a copy of an e-mail that had been sent to all team members explaining their responsibilities and the reasons why this was needed. Two staff members brought this e-mail to our notice and told us they felt that clarity was beneficial to staff members and patients.

Staff told us they felt supported and that a de-brief happened following incidents. One staff member told us that following a recent incident they had been supported immediately by a senior nurse, that they had been involved in a 72 hour de-brief and that they had been contacted by telephone when off duty to check that they were feeling all right following the incident. We saw evidence in one patient's notes of an incident de-brief occurring with the patient following an incident.

We saw how staff learnt from incidents. We reviewed team meeting minutes that indicated incidents were discussed and that the relevance to the service highlighted. We saw evidence of staff being actively encouraged to learn from incidents in the staff reflective practice session we attended.

Are services effective?

Good 

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our findings

Assessment of needs and planning of care

Of the six care records we examined, all had a comprehensive and timely assessment completed after admission to the unit. This meant that patients' needs were identified and care planned so they were met.

All six records we examined contained a completed physical health assessment. Where there were physical health issues, care was planned so that the patient's needs were met. We heard evidence at the handover we attended of the on-going review and monitoring of physical health issues. This meant that patients' physical health needs were met.

All the care records we examined were current and considered the holistic needs of the patients. There were clear outcomes that were recovery focused. Being recovery focused means helping patients to be in control of their lives and build their resilience so that they can stay in the community and avoid admission to hospital wherever possible.

The records were kept securely in the locked nurse base. The records were available and used by all members of the multidisciplinary team. The records we examined followed a chronological order, making it easy for all staff to understand and minimising the chance of information being missed.

Best practice in treatment and care

All the staff members that we spoke with stated that de-escalation techniques were employed and restraint would only be employed if this had failed. Fairhaven had not used any form of restraint in the previous three months.

We reviewed 10 medicine cards; all regular prescriptions were in line with current prescribing guidance. There were four medicine cards where as required (PRN) medication had not been reviewed for 14 days. In three of these, the PRN had not been utilised; therefore the prescription was not current and may not have been needed.

We were told that cognitive behavioural therapy (CBT), family therapy, and dialectic behaviour therapy was available to the patients. We saw evidence of psychological interventions in the care plans we reviewed. We saw that staff had completed CBT training and there were plans and

agreed funding for a further identified staff member to undertake this training. We were told that support and supervision was provided by the psychologist within the team.

Staff used the children's global assessment scale (CGAS) to assess social and mental state and reviewed progress against health of the nation outcome scales (HoNOS). This meant that patient outcomes were monitored. Of the six care records examined, all had a completed CGAS and HoNOS ratings present. All records had an assessment of the patient's capacity.

Ward staff were actively involved in audit. There was an audit of medication cards, an audit of detention papers and an audit of patient records. We saw the audit forms completed for the medication and case notes and we were able to track how named nurses had been contacted regarding required updates or changes. Examples of issues identified included care plans not being reviewed as agreed, rights under the MHA not being completed in a timely manner and missing signatures on records. We were also able to see how this was further followed up if not completed by the next audit and we saw evidence of e-mails sent to the staff members requesting they update or change case notes.

The ward had recently agreed to be part of a national audit supported by a local university looking at raising disability awareness from a children and adolescent mental health service perspective.

All 10 medication charts were within BNF prescribing limits. The prescriptions were valid for the patient group and in line with current Maudsley prescribing guidelines. This meant that patients received recommended medical treatments.

Skilled staff to deliver care

The ward team consisted of a good range of professionals. There were two doctors – one consultant and one staff grade, 13 qualified nurses, one social worker, one psychologist, one psychology assistant, one occupational therapist and nursing assistants. The ward also hosted both nursing and social work students. There was access to a family therapist one day a week. The hospital pharmacist visited the ward at least weekly and completed medication reconciliation on admission. This meant there was a good range of professionals to support the patients holistically.

Are services effective?

Good 

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

There was a full time teacher and a teaching assistant who offered 24 hours of education per week. Ninety eight to ninety nine per cent of the patients attended a minimum of 21 hours education. We were told that patients had just completed their GCSEs. One patient told us that they were expected to gain eight GCSEs from the 16 exams they had taken. This meant that the patients' education was on-going and not interrupted.

There were a mixture of experienced and newly qualified staff on the ward. One new member of staff told us that they felt they had received a good induction onto the ward and that they had felt supported by the ward team. A student on the ward told us they had felt welcomed and included in the team.

Staff told us that they received regular supervision and we saw records that reflected this. The deputy managers supervised the staff nurses and the staff nurses supervised the nursing assistants.

We attended a staff reflective practice session. It was facilitated by the ward social worker although normally it was facilitated by a family therapist external to the team. We observed that team members present were included in the session. The session was used to discuss both clinical issues and staff issues. Staff were encouraged to explore issues and then collectively worked together to develop an action plan; the team were supportive of each other and offered suggestions.

Staff told us that they attended team meetings and we saw minutes to support this. Team meetings were used for information sharing but also as a venue for staff to raise any ideas or issues.

All non-medical staff had had an appraisal in the previous 12 months.

Staff told us that training opportunities were good and supported by the trust. One staff member had recently completed CBT training and another one was due to start in September 2015. One staff member was due to commence a master's degree in September 2015. One doctor had completed a specialist training day in relation to autism. We were told that there were secondment opportunities for unqualified staff to gain professional qualifications. This meant that the staff were supported to develop and the skill levels on the ward kept improving, meaning the patients had a better experience during their stay.

Staff were not subject to performance reviews although we saw evidence that performance was continually addressed through the regular ward based audits. We saw the completed audits and also saw the e-mails to staff members where they fell below expected ward standards in relation to care planning, risk assessments or medicine administration records.

Multi-disciplinary and inter-agency team work

The ward held a weekly multi-disciplinary meeting (MDT) to discuss and review patients. We observed one MDT attended by medical staff, nurses and a student social worker. We observed the team to briefly review each patient over the previous 24 hour period. Medication compliance, mental state, risk issues, physical health issues, MHA status and patient leave were discussed during the meeting. This ensured that individual patient need was reviewed.

The ward held a handover daily between each change of shifts; this was attended by all professional groups which meant that the sharing of information was enhanced.

We observed two CPAs. One CPA was to plan the transition from CAMHS service to adult mental health. There was open discussion with the patient and family. There were plans in place for adult services to meet with the ward team, the patient and family members. Other attendees were from the adult housing and support services, who discussed how they would support the patient if discharged, including financial needs. This ensured that the patient had their needs met by a holistic care plan. In another CPA we saw how carers' needs were met by a referral to family therapy and a carers' group.

The ward team and higher management told us that it was sometimes difficult for community based care coordinators to attend CPAs and ward reviews. There was no representative from the community CAMHS teams at the two CPAs we attended.

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

The ward team completed annual Mental Health Act (MHA) e-learning. The ward manager informed us that all staff were either up to date or booked to complete this training. The medical staff team had received a one day update on the revised MHA code of practice. The three senior ward staff that we spoke with had a good understanding of their obligations in relation to the MHA.

Are services effective?

Good 

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Three patients were subject to the MHA at the time of our visit. All three patients had consent to treatment forms with their medicine cards, this meant that staff had discussed their medication with them and explained why they were taking it. The patients had agreed to take their medication.

We were told that staff routinely read patients their rights; daily for Section 2 MHA and monthly for Section 3 MHA. Staff documented this in the patients' care plans. On the notice boards we noted that there were leaflets explaining rights under Section 3 of the MHA; the format was user friendly and age appropriate. There were no leaflets for Section 2 MHA. When asked about the lack of Section 2 leaflets we were informed that staff replaced them regularly but they kept disappearing.

The ward routinely audited all detention paperwork at least every 2 weeks.

The trust had a central team that acted as co-ordinators for the MHA and a source of advice. Staff members knew about this team and stated they would contact them for advice if they were unsure about a patient's section papers or if they were having a tribunal to challenge their section.

The ward had a regular specialist independent mental health advocate (IMHA) for young people who visited the

ward weekly. If there was a request from a patient, the IMHA would attend ward rounds. Requests for IMHAs could be made either via e-mail or telephone. We saw leaflets on the notice boards advising of this service.

Good practice in applying the Mental Capacity Act

The Mental Capacity Act (MCA) act does not apply to young people aged 16 or under. For children under the age of 16, the young person's decision making ability is governed by Gillick competence. The concept of Gillick competence recognises that some children may have sufficient maturity to make some decisions for themselves. The staff we spoke to were conversant with the principles of Gillick and used this to include the patients where possible in the decision making regarding their care.

Ward staff completed training in MCA via e-learning.

There were no deprivation of liberty safeguarding (DoLS) applications made in the previous 6 months. A DoLS would be made if a patient was not ill enough to be placed on a mental health section and if staff had identified high level risks of a patient leaving the ward.

Staff were aware of the five principles of the MCA and applied them in their work. Staff were aware of the existence of a mental capacity policy. Staff told us they could refer or consult with the team social worker if needed.

Are services caring?

Good 

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

Our findings

Kindness, dignity, respect and support

We observed staff to be responsive to patient need and requests throughout our visit. We observed that staff were respectful to a patient and carer during a CPA meeting we attended. We noted that the patient and carer were given lots of opportunity to say what they felt or wanted. We noted that the patient's dignity was upheld during difficult conversations and that staff provided both practical and emotional support. At the weekly group meeting we noted that emotional support was offered to a patient in a sensitive and supportive manner.

All eight patients that we spoke to reported they felt that their admission to Fairhaven had been a positive experience. Three patients stated they felt the staff supported them emotionally and that they had only been able to talk openly since coming to Fairhaven. All eight patients were positive about the support they received from the staff.

We observed during the MDT meeting that staff understood the individual needs of patients. The interactions that we observed demonstrated that the staff treated the patients as individuals and were responsive to their individual needs. The care plans that we reviewed were individualised and tailored to individual patient need.

Patients told us that they felt involved in their care and that their wishes were acknowledged and met where possible.

We saw in case notes that the patients were involved where possible in the decision making about their care. Patients told us that they felt involved and one patient told us about the shout participation project. Shout was an initiative to engage with patients and for them to develop a meaningful voice.

The involvement of people in the care that they receive

We were informed of the admission process to the ward. We were shown a booklet that was given to patients on their admission to Fairhaven. The booklet gave an overview of what to expect, patients' rights and probable experience. The booklet had an area for completion of key individual details; case manager, named nurse, associate nurses, keyworkers, and consultant psychiatrist. We were informed this was completed at the point of admission.

We were told and we saw in patient records that patients were involved in the development of care plans and activity schedules. Patients confirmed that they had been involved in their care plan development. This meant that patients were active partners in their care.

During the CPAs that we attended there was clear consideration of the patient and their carer being involved in the forward planning of care. We noted they were given lots of time to contribute their needs and wants; this meant that patients and carers were listened to.

On the ward notice board there were advocacy leaflets and we were informed that an advocate visited each week. The advocate was happy to attend ward reviews if requested. Requests could be made by either telephone or e-mail.

We observed a weekly community meeting; we were told it was all about the patients bringing in what they want to discuss. The patients were informed that a play station was on order, something they had previously asked for. Patients discussed food; 'miss home meals', 'food is free', 'food orders sometimes get mixed up', 'we have a weekly lunch club'. The interaction appeared relaxed and informal.

In the room used for schooling there was evidence of recent craft activity and the walls displayed art work completed by the patients. We saw art work by patients throughout the ward and the outside areas.

Are services responsive to people's needs?

Good 

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

Our findings

Access and discharge

Average bed occupancy for the past 6 months was 94%, above the trust target of 85%. Despite this, we were told there were no current out of area placements due to lack of local availability. There was currently one patient who was from out of area who had chosen to remain at Fairhaven to complete their treatment rather than returning to their local area and this had been agreed by all involved to be in the patient's best interests.

Patients who were on leave had a bed to return to as we were informed that leave beds were not used to admit patients.

We were told that discharge was planned from the date of admission. Review CPAs happened every two weeks with patients. We were told that discharge planning was to meet the needs of the patient and if discharge occurred at an evening or weekend then this was at the patient's or family's request.

Although there had been no delayed discharges in the past six months, staff told us that delays did occur due to there not being sufficient appropriate placements for patients.

The facilities promote recovery, comfort, dignity and confidentiality

The ward had a good range of rooms. The clinic room was equipped with a couch and examination equipment. There were teaching rooms which showed the work that the patients had completed. There were several smaller quiet areas that could be designated as single sex accommodation if needed. The lounge was smallish and one staff member told us they thought this was too small to allow 'young people to roam'. The ward had an occupational therapy kitchen for patient use, which we were informed was used for individuals and group activities.

There was a public payphone that was readily accessible to the patients. Patients were allowed to bring their own mobiles into the ward but they were kept safe by the staff until patients wanted to use them. On our visit we observed three service users having access to their own personal mobiles when requested. The ward also had a handheld phone which patients could use if they requested to.

The ward had two separate outside spaces but one area was currently not being used as it was awaiting improvements so it was safe for use. This had been escalated on to the risk register. The area that was used was large with seating areas, recreational areas and an area for gardening. We were informed that the area was used for all types of sports including football and archery, using soft tipped arrows. The area was only accessible with staff supervision. This area was also used for smoking if the patients had their parents' permission to smoke.

The ward team explained to us the process they used to add items to the trust risk register. The team raised issues at the monthly CAMHS service meeting and then this fed into the trust monthly risk meeting. There was one item currently on the risk register for Fairhaven, which related to the bathroom having a damp area. We saw that plans were in place to remedy this.

We were told that patients could individualise their bedrooms. One patient allowed us to view their bedroom, which contained photographs, posters, artwork and other personal items, making it appear more homely.

The patients had access to hot and cold drinks 24 hours per day. Snacks such as fruit and yoghurt were available 24 hours per day but access to patient's individual 'tuck' boxes was limited to three times per day. The access to 'tuck' was negotiated through the ward meetings with patients agreeing what times the access would be.

The ward had a weekly planner of activities that was negotiated with the patients on a weekly basis. Regular activities were the weekend brunch club and the weekly sandwich club, which patients told us they enjoyed. We also saw photographs of the patients taking part in activities such as trips to theme parks, bicycle riding (the ward had 8 bicycles), outdoor pursuits and on every week a group visited with various animals. We saw photographs of patients with iguanas, rabbits and other small animals.

The ward had electronic comments and complaints stations situated on the main corridors where patients could anonymously submit their views to the trust. We were told that feedback was then received by the ward and this would be acted on. We were given a recent example in relation to the food, which had led to a change in the frequency of food being prepared on the ward.

Are services responsive to people's needs?

Good 

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

The patients had asked via the ward meeting for a daily activity to occur off the ward. Staff had responded by ensuring at least one activity each day was based off the ward.

On a recent PLACE audit completed, Fairhaven scored 100% for cleanliness, 100% for ward food and 88% for food provided. Condition, appearance and maintenance scored 83%. One patient told us that the ward environment had improved since their last admission. The ward was noted to be in fair condition and furniture was in good repair.

The ward operated a support group for carers every two weeks. We were told that the attendance at this varied but that the group was available as a support to parents.

We saw active activity programmes that both staff and patients told us occurred each day, including weekends. One patient told us that sometimes activities were cancelled due to a lack of staff. We saw evidence that where activities were cancelled it was because a patient had become unwell and staff were needed to stay on the ward.

Meeting the needs of all people who use the service

The ward was on a single level and the en-suite shower facilities were of a wet room type that would allow disabled access.

We observed that notice boards in the ward contained information leaflets regarding services such as advocacy, rights under the MHA, how to raise a concern or complain, and treatments. The leaflets provided were age appropriate for the patient group.

There was a lack of leaflets in languages other than English or easy read format. We asked staff about this and we were informed that the patient group was primarily English speaking but that if needed they could get translation services and access leaflets in other languages through the Trust. We were told that leaflets in other formats were available through the Trust.

We were told that there was no issue with dietary needs being met. We were told the central kitchen had provided halal and kosher food for recent patients and this had been facilitated via one phone call.

The ward received a weekly chaplaincy service that patients could access if they wished. Staff told us they would arrange for other clergy from other faiths to visit if patients wanted this to happen.

Listening to and learning from concerns and complaints

Fairhaven had received five complaints in the previous 12 months; of these complaints three were upheld. No complaints had been referred to the Ombudsman.

The staff we spoke to were aware of how to deal with complaints and the process of dealing with formal complaints.

There were no outstanding complaints regarding Fairhaven.

We were told by both ward and senior staff that once complaints were completed, any learning indicated would be disseminated via the monthly CAMHS service meeting. We were told that this information would then feed into the ward team meeting for the ward team to action.

Are services well-led?

Good 

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

Our findings

Vision and values

Staff interviewed were generally aware of the trust's vision and values. The senior staff were able to describe how these values fed into the team's vision for the ward and were translated into patient care.

Ward staff were aware of the senior managers within the Trust. We were told of occasions when senior managers had visited.

One senior manager visited the ward each week to run a reading group. We were able to observe this group; the group read through a play with all members taking a role. After the reading finished, the manager spent time discussing the play with the patients and each one was encouraged to give their own individual view. This meant that the ward team and patients were connected to the senior management team.

Good governance

There were effective ward systems to ensure that staff received mandatory training, appraisal and supervision. The ward was covered by sufficient staff of the right grade and experience to meet patients' needs.

We found that patients' needs were met as staff maximised the time they spent on direct care activities.

There was an open culture that actively encouraged the reporting of incidents and processes were in place to facilitate learning from incidents and complaints.

The ward team had a good understanding of the MHA and the MCA and safeguarding procedures.

The team was actively encouraged to report all incidents so that the ward could learn, improve and be transparent.

The ward manager had sufficient authority to manage the ward and had the authority and processes in place to raise issues at Trust level.

Leadership, morale and staff engagement

The sickness absence rates for June 2015 were 3%.

The ward had no current bullying or harassment cases.

The staff that we spoke to were aware of the whistleblowing process. One staff member demonstrated how they could do this using the electronic system. Staff were able to retain their anonymity if they wanted to.

The staff members who we spoke to told us they would feel confident to raise concerns without the fear of victimisation. One staff member told us that the culture was an open one where staff are encouraged to raise issues or incidents so that the team can learn. We were told by staff members that when things went wrong an explanation was always given to the patients and that an open culture operated. This reflected the trust's duty of candour.

The staff members that we spoke to all reported feeling happy in their roles. A new manager had started and staff told us that they felt that the culture of the ward had changed and that they were more empowered to do their jobs.

We were told and observed that staff were actively given responsibility for key areas and that they were able to lead on these within the team. Examples included a healthcare assistant who shared lead responsibility for safeguarding within the team and more senior nurses who were responsible for on-going audit and the improvement of care plans and risk assessments.

We were told that one of the best things about working at Fairhaven was that the ward worked as a team. We were told how staff were supportive of each other and we observed this support during the reflective practice session we attended.

We saw that during meetings all staff members were able to give feedback and make suggestions for service development.

Commitment to quality improvement and innovation

The ward had been approached to become involved in a national audit, looking at disability from a CAMHS perspective.

Fairhaven was working towards the Royal College of Psychiatrists' accreditation for in-patient child and adolescent services, Quality Network for Inpatient CAMHS (QNIC) and hoped to achieve this by March 2016.

In 2014, Fairhaven was runner up team of the year in the staff recognition awards.