Nottinghamshire Healthcare NHS Foundation Trust

Child and adolescent mental health wards

Quality Report

Thorneywood Unit
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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)
RHAPB	Thorneywood Unit	Thorneywood Unit	NG3 6AA

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

Summary of findings

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

- The ward was clean and comfortable. There was a range of rooms available. Staff ensured the building was fit for usage by completing environmental audits.
- Staff completed mandatory training. Staff had good practical knowledge of the Mental Health Act and the Mental Capacity Act. Staff knew when and how to raise a safeguarding alert meaning that they knew how to keep young people safe.
- Young people and carers told us the service was good. They told us the staff treated them with kindness, dignity, and respect.
- Young people had current care plans and risk assessments. Staff completed patient assessments and reviews in a timely manner.
- Care plans were recovery and outcome focused.
- Young people had a physical health assessment on admission to the ward. Staff monitored young people's physical health throughout their stay.
- Staff provided activities, trips out, music groups and cooking. Young people received 25 hours of education each week in school time provided by staff.
- Young people knew how to raise concerns and said they would be confident to do this.
- The staff team consisted of a range of professionals who worked effectively as a team. Staff members felt happy, valued, and supported.
- Staff delivered person-centred care in a kind and respectful way.
- Staff used national guidance to inform the young people's care.
- Staff told us they felt supported and confident about raising concerns.
- Staff reported incidents and had systems to share learning.

However:

- The ward did not have a separate female-only lounge. Staff were aware of this and, given the constraints of the building, did what was possible.
- Staff did not allow young people in the low stimulus area to leave. A low stimulus area is to give young people a chance to be away from others if they are becoming distressed. We were concerned the young people were subject to unfair restrictions if staff prevented them from leaving when they wished.
- The service did not follow a specific child and adolescent mental health service CAMHS care pathway. This would have directed staff about the care they provided and indicated timescales to aim for.
- Young people said bank staff were not as good as the ward staff.

Summary of findings

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

Are services safe?

- The ward was visibly clean. The ward was comfortable, there was age appropriate furniture for the young people to use.
- Mandatory training was completed.
- The service contained a mix of staff from different professions and grades.
- The ward managers had the authority to adjust staffing levels to meet young people's needs.
- The clinic room was well equipped and staff regularly checked the equipment to make sure they treated young people safely.
- Each young person had a regularly updated risk assessment, which kept the young people and staff safe.
- Staff assessed and monitored the physical health needs of patients.
- Staff completed safeguarding training and knew how and when to raise safeguarding alerts.
- Staff learned from incidents and complaints.
- We saw evidence of the duty of candour with staff offering apologies when things went wrong.
- Staff completed assessments of the environment to keep young people safe.

However:

- The ward did not have a separate female-only lounge. Staff were aware of this and given the constraints of the building did what was possible.
- Staff did not allow young people in the low stimulus area to leave. A low stimulus area is to give young people a chance to be away from others if they are becoming distressed. We were concerned the young people were subject to unfair restrictions if staff prevented them from leaving when they wished.

Are services effective?

- Staff assessed each young person's needs on admission and regularly reviewed them.
- Care records were recovery focused, up-to-date and personalised so staff treated young people as individuals.
- Staff assessed patient outcomes on an on-going basis using recognised tools.
- The multidisciplinary (MDT) team contained a range of professionals.
- Staff received regular supervision.

Summary of findings

- Staff used national guidelines to inform the treatment of young people.
- Staff had training in, and provided, talking therapies. Staff had good practical understanding of the Mental Health Act (MHA) and the Mental Capacity Act (MCA).
- The staff worked collectively as a team to meet young people's needs.

However:

- The service did not follow a specific CAMHS care pathway. This would direct staff about care they provided to young people and timescales.

Are services caring?

- Young people told us staff treated them with respect and dignity.
- The interactions we observed were respectful of the individuals and upheld their dignity.
- Interactions were relaxed; staff were responsive to requests made of them.
- Young people said talking to staff helped.
- Young people and carers told us staff were kind and approachable.
- Staff actively involved young people and carers in the planning of care.
- Young people had copies of their care plans.
- Young people could access advocacy services.

However:

- Young people said bank staff were not as good as the ward staff.

Are services responsive to people's needs?

- Staff met young people's individual needs.
- Discharge planning included the young people and was reviewed and updated throughout their stay on the ward.
- Rooms and facilities appropriate to young people were available and there was access to fresh air and outdoor space.
- The food provided was good and met individual dietary needs and preferences.
- Young people received 25 hours of education a week during term time.
- Young people said the education provided was good.
- Activities took place.

Summary of findings

- There was a range of equipment and resources for young people.
- Young people with disabilities, including wheelchair users, could access the ward.
- Young people told us they felt confident to raise complaints.
- Staff knew how to address complaints.

Are services well-led?

- Staff told us they were happy in their roles and worked together as a team.
- Staff felt they did a good job.
- There was an effective MDT team.
- Staff young people and carers communicated effectively.
- Staff told us they felt valued and supported.
- Managers were visible and staff felt supported by them.
- Sickness absence rates were 2% or below for the previous four months.
- The service employed a peer support worker.
- The ward had systems for monitoring mandatory training.
- Staff told us they would be confident to raise concerns without fear of victimisation or reprisals.
- There were no bullying or harassment cases.

Summary of findings

Information about the service

Nottinghamshire Healthcare NHS Foundation Trust child and adolescent mental health wards provide services at Thorneywood young people's unit.

Thorneywood has 13 beds and provides inpatient mental healthcare for children and young people aged between 12 and 18. The service offers assessment and treatment. Both males and females are admitted for a range of reasons. The service provides individual and group-based therapies.

We last inspected Thorneywood 29 April to 2 May 2014.

The service was issued with one compliance action:

Regulation 10 (1)(b)

The trust had not arranged for gender segregated living accommodation or 'female only' communal areas within Thorneywood inpatient ward.

On the day of our inspection, the trust had not provided gender segregated living accommodation or a 'female only' lounge. However, the trust had taken steps to meet the individual needs of young people within constraints of the building.

Our inspection team

The team comprised:

- two Care Quality Commission (CQC) inspection managers
- a CQC inspector
- a specialist adviser, and
- a Mental Health Act reviewer.

Why we carried out this inspection

We inspected this core service as a follow up to a comprehensive inspection previously completed, to assess if the provider had met the compliance action issued.

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information we held about the service.

During the inspection visit, the inspection team:

- visited the inpatient ward
- looked at the quality of the ward environment, and observed how staff were interacting with, and caring for, young people
- spoke with four young people
- spoke with four carers/family members
- spoke with the nurse in charge
- spoke with three nurses of various grades
- spoke with a consultant doctor
- spoke with two student nurses

Summary of findings

- spoke with an activities co-ordinator.

We also:

- looked at 12 medication records
- looked at six care records
- carried out a check of medicines management
- looked at a range of policies, procedures and other documents relevant to the running of the ward
- observed interactions between young people and staff
- attended a ward multidisciplinary team (MDT) meeting
- attended a handover
- looked at the clinic room, emergency equipment, and ward facilities
- observed interactions in the lounge area.

What people who use the provider's services say

Young people described ward staff very positively and said they were available. They told us talking to staff helped. They received regular one-to-one time with staff. Activities and leave went ahead. The activities co-ordinator had supported them with trips out from the ward. They said food, education, and advocacy were good. Young people were confident staff met their physical health needs. Carers said staff were kind and approachable. Young people knew how to complain and said they would feel confident doing so. Young people reported bank staff were 'not as good' as regular staff.

Areas for improvement

Action the provider SHOULD take to improve

- Review the use of the low stimulus area to ensure staff are not preventing young people from leaving when they wish.
- Ensure that bank staff have enough information to meet individual young people's needs.
- Ensure that planning and development of services addresses gender-specific needs.

Nottinghamshire Healthcare 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
Thorneywood Unit	Thorneywood Unit RHANP

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 Trust has a central team that act 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.
- The staff team completed Mental Health Act (MHA) training. At the time of inspection, 12 of 16 staff had completed the required training (75%). We saw a further staff member was booked to complete it. Staff had a good working knowledge of the MHA.
- One patient was subject to the MHA at the time of our visit. The patient had a valid consent to treatment form. A second opinion approved doctor had seen them, as required. Initially a medical recommendation form was missing from the patient's notes. The centralised MHA administration team later provided this. A tribunal had reviewed the detained patient and we saw a copy letter informing them of their right to a hospital managers hearing. This meant legal obligations were met.
- We found notes contained evidence of staff giving the detained patient their section 132 rights. We saw staff regularly reviewed this. There was a record of their right to an independent mental health advocate (IMHA). The IMHA service was available on set days, three days each week. A young person was informed they had been discharged from the MHA this was recorded. The ward had devised age appropriate, information packs for young people where they could read their own rights from the resources developed. Staff offered young people an information leaflet on admission citing their rights. Three of the four young people we spoke to confirmed receiving this leaflet on admission. This meant young people were aware of their rights.

Detailed findings

- We found section 17 leave was authorised, using standardised forms. The forms clearly stated the conditions of leave. We found staff regularly reviewed section 17 leave. We did not find evidence staff sought patient views following leave.

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 some children may have sufficient maturity to make some decisions for themselves. The staff we spoke to were familiar with the principles of Gillick and used this to include the young people where possible in the decision making regarding their care.
- The staff completed MCA training. At the time of inspection, 14 of 17 staff had completed the training (82%). Staff could give a good overview of the MCA. Staff were aware of capacity issues.
- Care records showed staff assessed capacity and consent sought appropriately from young people or their parents/ carers. This meant young people and their families were involved and agreed to their treatment.

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

- Staff carried out assessments of ligature points. Ligature points are places to which young people intent on self-harm might tie something to strangle themselves. The layout of the ward made it difficult to observe all areas. The staff were aware of this and mitigated this risk through observing young people away from the main day area; we saw this while visiting the ward. Mirrors were in corridors to try to enhance observation. The low stimulus room had areas that were difficult to observe but had mirrors to manage this.
- The clinic room was fully equipped, clean, and tidy. Staff completed checks of fridge temperatures to ensure medicines were safely stored. The drugs in the emergency bag were in date, meaning, if needed, they were safe to administer.
- A monitoring of infection, cleanliness, and environment audit (MICE) completed in March 2015 scored positively. Scores for cleanliness 95%, infection control 96%, environment 100%, privacy, and dignity 93%. The bathroom areas and disabled toilet had emergency call buttons; bedrooms did not. Staff were not able to tell us why this was. Staff closely monitored young people if risk was identified. Not having a call system throughout the ward meant it did not meet the standards required by the quality network.
- Environmental risk audits were completed and reviewed; staff assessed the suitability of the environment.
- The ward had designated male/female toilet facilities. One corridor contained the bedrooms. Staff tried to keep male and female young people separate by placing the males at the far end of the corridor, where the male bathrooms were. Female bathrooms were in the centre of the corridor. This was the area where the female bedrooms were. No bedrooms were en-suite and some young people shared bedrooms meaning some young people did not have the option of their own room. This would impact on privacy. The ward did not have a female only lounge, due to limited rooms being available. No young people had made requests for gender specific space. The ward manager informed us multi-use rooms were available if needed.
- The ward did not have a seclusion room. It did have a low stimulus area (LSA). We saw there was a procedure relating to use of the low stimulus area. The room had washing and toilet facilities and was well ventilated. The LSA did not contain a clock so it would be difficult for young people to know how long they had been there. The side room adjacent to the LSA was cluttered and staff appeared to use it for storage; this could have posed a risk to young people using the facility.
- The furniture was in good condition. We saw age appropriate seating, such as beanbags.
- The ward environment was clean. We noted domestic staff were carrying out cleaning duties whilst we were there. Cleanliness in hospital audits carried out in February, March, and May all achieved passes. The gym area had clutter present and it appeared staff used it for the storage of items awaiting disposal. We saw empty paint cans, TV's, filing cabinets, and office equipment. This did not provide a welcoming environment for the young people and could have posed risks to them.
- Staff carried personal alarms to summon help if required. Two student nurses on the day of inspection did not have personal alarms. They told us not enough alarms were always available and students were less likely to be given an alarm by staff if there were shortages. This meant young people and staff could have been at risk if support was needed. They would not be able to summon help.

Safe staffing

- Thorneywood ward's staffing establishment was 14 whole time equivalent, qualified nurses. At the time of inspection, there were two qualified nurse vacancies. Recruitment was in progress for these posts. There were 10 health care workers in post. A concern regarding ward-staffing levels had led to the Thorneywood staffing team going onto the trust risk register in 2014.
- The trust identified staffing levels. The ward operated three shifts per day system. Four staff each morning,

four staff each afternoon, and three staff at night. On the day of our inspection, staffing levels were as expected. The staff rotas we checked had the number of staff required.

- From 1 April 2015, to the date of inspection, bank or agency staff had covered 1,060 single shifts. The majority of these, 1,044, had been filled by regular bank staff and 16 by agency staff. A further 111 shifts were not filled. The ward manager helped when short staffed, or asked staff to come in, or to change their shifts. The ward manager told us if staffing levels could not be met the staff team would risk assess the young people to do a group activity to manage the risk and observations levels. One healthcare worker felt the ward was short of staff two or three times each month. Young people said sometimes that they had to wait for staff to be available. Young people reported staff did not cancel activities or leave. The occupational therapist and activity worker were able to facilitate activities and leave, as they were supernumerary; this means they were not part of the nursing team based on the ward.
- The ward manager had the authority to adjust staffing levels to meet patient need.
- Throughout our inspection, a qualified nurse was present in the main communal area. Staff and young people told us this was normally the case.
- Staff informed us young people had regular 1:1 time with their named nurse. Three of the young people we spoke to said they received regular 1:1 time with staff. We saw care records contained evidence of this.
- The ward had an activities co-ordinator who was supernumerary to the staff team. Activities included trips out, arts and crafts and playing games.
- Medical staff were based on the ward Monday to Friday from 9am to 5pm. Outside of this, emergencies were responded to by the out of hours, on-call doctor system for the hospital.
- Staff accessed mandatory training. We saw 76.76% of staff were up to date with the required training on the date of the inspection. However, two weeks earlier 88.44% were up to date with their training. We saw plans were in place for staff members to update their training. Fire training was completed by 21 of 35 staff (60%), two staff members had this training booked. 25 of 35 staff (71%) completed manual handling; one staff member was booked to complete this. Equality and diversity training was completed by 22 of 35 staff (63%), one staff member was booked to complete this. Basic life support training was completed by five of seven staff; one staff member had a date booked to complete. Hand hygiene training was completed by 20 of 34 staff (59%). All other training was in excess of 75% for staff trained. This meant the staff team received the training required to complete their roles.

Assessing and managing risk to patients and staff

- Staff spoke confidently about the use of de-escalation techniques. Staff only used restraint if de-escalation techniques failed. Staff gave examples of talking to young people or using distraction techniques. No young person on the ward had a care plan for restraint. Staff told us this was because no one currently required this intervention. Staff used prone restraint to prepare for the administration of rapid tranquilisation medication. Staff members were familiar with the extra requirements associated with the use of rapid tranquilisation medication and the need for a specific care plan. No young person had a care plan for rapid tranquilisation.
- Six care records were reviewed. As part of the admission process, risk assessments were completed. We found risk assessments were detailed and reviewed periodically. Staff used the risk assessment level II tool. This looked at current and historical risks. This tool guided decisions regarding levels of observation of the young people. Staff assessed young people and appropriately supported them.
- Young people were subject to some restrictions. Staff provided a list of acceptable items and behaviours to young people. The list concentrated on restrictions and behaviours parents of young people would impose. It included DVD's must not be rated 15 or above, MP3 players should not have cameras, no ear stretching allowed on the ward. Young people could only use phones between 6.30pm and 8.30pm. Access to bedrooms was limited from breakfast time until 9pm each evening. Staff and the patient's we spoke with said young people could access their bedrooms outside of these times if they wished to, accompanied by staff. Staff for access to some items completed individual

assessments. An example of earphones was given, as these could be used by young people to self-harm. Young people were not allowed to smoke; staff offered young people nicotine replacement patches.

- The ward had locked doors. There was a notice on the main door advising young people what to do if they wished to leave. This meant young people were aware of their rights.
- Policies and procedures were in place to support actions staff should take. We saw a range of policies specific to the service. We saw: use of ligature knives in CAMHS, a protocol for the use of low stimulus areas for CAMHS, medicine round and medicines management operating protocol for CAMHS. This meant procedures were in place specifically to guide staff working with young people.
- Staff received level three children's safeguarding training. Children's safeguarding training was completed by 29 out of 31 staff (94%). We saw 11 staff had plans to update. Adult safeguarding was completed by 24 of 31 staff (77%). Staff knew how to raise a safeguarding alert. Staff logged safeguarding concerns electronically. The clinical nurse specialist was the team lead for safeguarding. They were the contact with the local authority, and offered advice to other staff. Staff spoke confidently about what may be abuse. Staff gave examples of different types of abuse. Two student nurses said they were gaining valuable experience of safeguarding at this placement. They confirmed staff had shown the safeguarding policy as part of their induction. This meant staff were aware of their responsibilities and took measures to protect young people from abuse.
- Staff were aware of the specific needs of young people in relation to medicines. A staff member gave a thorough description of necessary monitoring for specific medications. Individualised care plans contained this information. A pharmacist visited the ward weekly to check the prescription cards and medication.
- There was a comfortable visitors/family room. Visiting was in the evenings during the week.
- Seclusion was not used on the ward. If a young person required seclusion, they would be transferred to a psychiatric intensive care ward. The ward had a low stimulus area (LSA). Young people told us at times staff had stopped them from leaving the LSA; staff we spoke with confirmed this. The team stated they were not secluding young people, as there was access to a bathroom and outside fresh air. We were concerned the young people were subject to de facto detention if not allowed to leave when they wished.

Track record on safety

- The ward had experienced a serious incident in the previous two months. A young person had attempted to strangle him or herself with a piece of string. Staff removed the string. The young person was unharmed. Staff had classed this incident as a near miss. The young person had taken the string from the education area. Consequently, staff had discussed risk assessment in relation to the area. A member of staff now accompanies young people to this area. This demonstrated the team learn from incidents and amended practice.
- Learning from incidents was shared with staff in a number of ways. Staff at handovers, team meetings, supervision, multidisciplinary team meetings, and e-mails sent discussed it. We witnessed staff discussion and saw minutes of meetings to reflect this.
- We were able to track an incident reported in care records. We found staff both recorded the incident electronically and in paper format. This reduced the risk of staff missing information.

Reporting incidents and learning from when things go wrong

- Staff we spoke with were confident of incidents they would report. They described the process for doing this. They gave examples of what they would report. Staff had reported medication errors, restraint, self-harm and verbal abuse.
- The ward manager gave two examples where staff had given apologies to young people/parents when things had gone wrong. They spoke about being open and transparent. This improved communication. This demonstrated the service was committed to the duty of candour.
- A student nurse told us following witnessing an incident staff had offered support and debrief. Staff debriefed young people following incidents. Debrief could be

informal at the end of the shift or could be a formal process with de-brief forms completed. Three staff members told us they felt debrief was necessary and provided a good learning opportunity. We saw records of planned debrief sessions, although only three of seven had taken place in the previous three months.

Are services effective?

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

Our findings

Assessment of needs and planning of care

- Of the six care records we examined, all had a comprehensive and timely assessment of need completed. There was a detailed history present. This meant young people's needs were identified by staff and care planned so they were met.
- All care records contained an initial physical health assessment and showed clear evidence staff reviewed and monitored this on an on-going basis. Records contained a physical health care plan. We found a female health improvement profile was completed and detailed. We saw staff completed weight monitoring. This ensured young people's physical health needs were met by staff.
- Care records were recovery focussed, up to date, personalised, and holistic. An acute care pathway recovery plan was present. This indicated staff treated young people as individuals.
- Paper records were stored appropriately in the ward office, which, we observed staff kept locked at all times. Young people's records were also kept electronically on the RIO system. We tracked two records and found staff recorded information on both systems; ensuring necessary information was readily available.

Best practice in treatment and care

- The national institute for health and care excellence (NICE) guidance informed the prescribing of medication, in consultation with Maudsley prescribing guidelines.
- There was a range of psychological therapies available to young people. The care records we reviewed contained care plans detailing psychological interventions. NICE guidance informed intervention. Depression guidance, self- harm and harm minimisation guidance, anorexia guidance, violence and aggression guidance supported care planning. This ensured young people received care of a nationally agreed standard. One nurse told us care planning could improve to include more evidence- based interventions.
- Two young people told us they had been able to access specialist physical healthcare when needed. All of the young people told us they were confident staff met their physical health needs.
- Staff used the Children's Global Assessment Scale (CGAS) to assess social and mental state and reviewed progress against HONOS; this meant staff monitored patients. Of the six care records examined, all had a completed CGAS and HONOS ratings present. All records had an assessment of patient capacity.
- Staff completed audits in relation to the clinic room. Staff carried out weekly checks of care plans and risk assessments as part of the multidisciplinary team review. The clinical nurse specialist audited the notes monthly via survey monkey, an electronic tool. This meant the service evaluated its own performance.

However:

- The service did not follow a specific CAMHS care pathway. This would direct staff about care provided and timescales. The team were aware of this. A lack of administrative support was highlighted by staff as negatively affecting this development. The administrative worker was part-time and had other duties that needed to take priority within the ward.

Skilled staff to deliver care

- The ward had a good range of disciplines; medical staff, nurses (both mental health and learning disability trained), health carers, psychology, family therapist, occupational therapist, dietician, clinical nurse specialist. The hospital pharmacist visited the ward weekly and completed medication audit. This meant there was a good range of professionals to support young people holistically.
- We saw records of regular staff supervision. Staff received group supervision, clinical supervision monthly and management supervision every four to six weeks. Records for 12 months showed between 44% (October 2014) and 88% (May) of staff had received supervision. Eight months were at 60% or above.
- The consultant psychiatrist received regular formal supervision. They could access informal supervision if the need arose.
- The two student nurses had received a comprehensive induction to the ward. They had been shown around the ward, been provided with the philosophy of care, and an induction pack. The induction pack contained policies, where staff kept things, for example the ligature knife,

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fire exits, reporting concerns, sickness, and who was their mentor. The students had regular meetings with their mentors. They identified other staff had offered them support and debrief.

- Psychological therapies such as cognitive behavioural therapy (CBT) and dialectical behavioural Therapy (DBT) were available. Staff received training in talking therapies. They aimed to help young people and their carers to identify extreme emotions and behaviours and work on these. DBT was Individual and group. A DBT group for parents had started to teach parents DBT techniques.
- Regular team meetings occurred, we saw minutes to support this. Information sharing, learning, and a venue for staff to raise ideas or issues were included.
- Staff told us training and development was available. Secondment opportunities were available for staff to widen their experience. Secondments had occurred to substance misuse services, youth offending team and self-harm team, demonstrating the team were developing specialist skills.

Multi-disciplinary and inter-agency team work

- We observed a staff handover attended by six staff. We found there was thorough discussion of each individual patient. Areas discussed included risks, leave, activities, physical health, activities, positive behaviours, mood, family dynamics, and eating patterns. There was a detailed knowledge of young people's behaviours. We heard staff discussed young people with respect.
- We observed one multidisciplinary team (MDT) review, which included a range of professionals, we noted interactions were relaxed and staff members contributed to the discussions. The team made appropriate referrals at the MDT to specialist services, eating disorder and mother and baby services.
- Community teams were involved in the care of young people. Five days after admission a care programme approach (CPA) planning meeting took place. The community team normally attended. Information exchange with community teams regularly occurred via phone or e-mail. This meant information sharing continued. Social services did not always attend or sent someone who did not know the young person.

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

- The Trust has a central team that act as co-ordinators for the Mental Health Act (MHA) and a source of advice, staff members knew about this team and stated they would contact them for advice.
- The staff team completed MHA training. At the time of inspection, 12 of 16 staff had completed the required training (75%). We saw a further staff member was booked to complete it. Staff had a good working knowledge of the MHA.
- One patient was subject to the MHA at the time of our visit. The patient had a valid consent to treatment form. A second opinion approved doctor had seen them, as required. Initially a medical recommendation form was missing from the patient's notes. The centralised MHA administration team later provided this. A tribunal had reviewed the detained patient and we saw a copy letter informing them of their right to a hospital managers hearing. This meant legal obligations were met.
- We found notes contained evidence of staff giving the detained patient their section 132 rights. We saw staff regularly reviewed this. There was a record of their right to an independent mental health advocate (IMHA). The IMHA service was available on set days, three days each week. A young person was informed they had been discharged from the MHA this was recorded. The ward had devised age appropriate, information packs for young people where they could read their own rights from the resources developed. Staff offered young people an information leaflet on admission citing their rights. Three of the four young people we spoke to confirmed receiving this leaflet on admission. This meant young people were aware of their rights.
- We found section 17 leave was authorised, using standardised forms. The forms clearly stated the conditions of leave. We found staff regularly reviewed section 17 leave. We did not find following leave staff sought the views of young people.

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 persons' decision-making ability is governed by Gillick competence. The concept of Gillick

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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.

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

- The staff completed MCA training. At the time of inspection, 14 of 17 staff had completed the training (82%). Staff could give a good overview of the MCA. Staff were aware of capacity issues.
- Care records showed staff assessed capacity and consent sought appropriately from young people or their parents/ carers. This meant young people and their families were involved and agreed to their treatment.

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- We observed young people treated with respect and dignity. They appeared relaxed interacting with staff. We spent time in the lounge and observed staff freely interacting with young people. Staff leaving shift said goodbye to the young people before leaving. We saw staff responded to requests made of them.
- At the multidisciplinary team meeting, staff treated the young people with kindness and compassion. Each young person's individuality was accepted and accommodated.
- Young people told us talking to staff helped. Young people described ward staff as 'really, really ace and involved in everything'. Staff initiated board games or made suggestions if young people were bored. We noted staff carefully picked up two part-made jigsaws so as not to damage them. This demonstrated staff respected and had regard for the young people.
- One young person told us the activities co-ordinator had supported them with trips out from the ward. He occasionally worked weekends.
- Carers said staff were kind and approachable. One carer told us how helpful she had found a meeting with the consultant the previous day. Both the carer and young person had concerns. They had contacted the consultant and were offered an appointment. They both felt reassured following the meeting; the consultant had explained the care pathway and normalised their feelings.
- Young people told us they were able to access private rooms for visiting or telephone calls.
- Individualised care plans were present and we witnessed staff discussing the individual needs of the young people.

However:

- Young people reported bank staff were not as 'good' as regular staff. One young person told us bank staff did not understand the importance of following care plans for eating programmes and portion sizes. Another young person said staff did not really understand autism. Two young people said night staff were noisy, 'talking and banging doors'. One young person said a member of staff had failed to respond to her when she had woken at night in a distressed state. We were concerned bank staff were not fully able to meet the needs of the young people.

The involvement of people in the care that they receive

- Three young people confirmed they had received an information leaflet on admission to the ward. One said their mother had received a leaflet. One young person said the leaflet was not up to date; information had changed about smoking and mealtimes. Staff introduced young people to the ward. Student nurses were familiar with the admission procedure. The young people were able to take a virtual tour of the ward via a website provided prior to admission.
- Young people had copies of their care plans. Care plans demonstrated young people were involved. A care planning group occurred weekly which, reviewed progress with the young person. Areas covered included: education, medication, mood, goals, what had gone well, and what had not gone so well. Staff helped young people record their views and read these out at the MDT on their behalf. Young people told us they were able to contribute to their care plans through the MDT meeting. One person did not agree with their care plan, they intended to address this through the MDT.
- Young people and their carers were involved in the care. Young people completed MDT sheets prior to their reviews. Carers/ families were liaised with following MDT reviews.
- Each week a 'step ahead' meeting occurred following the MDT meeting. It involved the young person, their carers, and professionals. The meeting was to ensure there was clear communication and updates. We saw carers on the day of inspection who had attended for step ahead.
- Staff carefully considered feedback from parents and carers following leave during the MDT we attended.
- Young people had access to advocacy services. The advocate base was at the ward. The advocate automatically approached young people following

Are services caring?

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

admission. Young people were aware of advocacy. One young person said advocacy was really good. This meant young people had assistance if needed to express their views.

- Weekly community meetings occurred. Young people made records. We saw records contained young people's concerns and actions taken. Extended visiting times were agreed in response to young people's requests. Staff listened to young people's feedback.
- One young person had been involved in staff recruitment, supported by the activities worker. Another young person had declined. This demonstrated young people were involved in making decisions regarding the service.
- The service was hoping to have a newly built ward within two years. Consultation had taken place with the young people.

Are services responsive to people's needs?

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

Our findings

Access and discharge

- On the day of inspection, 12 beds were occupied.
- A 17-year-old male was at a local NHS low secure service. Thorneywood could not meet his needs. We reviewed this placement as part of the inspection. We found plans were in place to transfer the young person to an independent medium secure provider. We found comprehensive joint working and reviews had taken place between the local commissioners, NHS England, home teams, current provider, and the proposed provider. The specialist consultant had remained involved throughout the admission of the young person and directed the young person's care and treatment. Staff made concessions due to the young person's age, including allowing the young person access to a phone whilst in seclusion. This was so the young person could remain in contact with his family. There was evidence plans were in place to smooth the move; the ward manager from the new provider was visiting as we left. Staff completed comprehensive records containing legal paperwork, assessments, decisions, and plans. We were concerned regarding the young person's on-going care needs.
- Referrals for local young people went directly to the ward. The ward team decided if the referral was appropriate. NHS England also admitted young people from other areas of the country to the ward.
- Staff did not use leave beds for new admissions when young people went on home leave. This ensured if young people needed to return to the ward early a bed was available.
- Discharge occurred early in the day planned by staff.

The facilities promote recovery, comfort, dignity and confidentiality

- There was a good range of rooms. There were areas where young people could spend quiet time, if they wanted. We saw artwork displayed young people had completed.
- The visiting room was well furnished and comfortable. Step–ahead meetings with families took place here.
- Young people could only make phone calls between 6:30 – 8:30pm. There was a phone in the advocacy office young people could use in private. Young people could put their own SIM cards into a ward non- photographic mobile to use. During family visits, young people could access their own mobile phones and access social media (Facebook/ twitter).
- There was a large outdoor space. The garden area was fenced and large enough for activities. The area was clean tidy and well maintained apart from a few weeds in the concrete area. Young people told us they could access this with staff.
- Varied menus were on offer. Young people told us the food was good. Meals were served at set times. Access to hot and cold drinks and snacks was at set times.
- Young people were able to put up posters in their bedrooms. Electrical items such as TV's, games consoles, MP3's and radios were not allowed in young people's bedrooms due to risk. We saw artwork on display in the dining room and art room young people had done.
- Education was not available to the young people, as it was holiday time. During term time, the service provided 25 hours of education. School hours were 9:30–12:00 and 1:00- 3:00. One young person told us staff had supported them to keep up with their main schoolwork. They said education was good at the ward. Education staff liaised with main school staff. A young person told us prior to discharge they would be gradually re-introduced into their main school.
- The ward provided activities. Young people enjoyed the activities offered. They told us it was a funny time as it was school holidays. Young people said activities were less frequent at weekends due to open visiting. We saw activities provided included cinema trips, cooking, music groups, art, and trips to town. The activities worker worked Monday, Wednesday, and Friday from 9 am until 9pm to provide activities in an evening. Occasionally he worked at a weekend to facilitate specific activities for the young people. One young person told us sometimes they were bored but staff made suggestions of what they could do. We saw there was access to board games, paints and colouring materials, DVD's and X box games.

Are services responsive to people's needs?

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

- A volunteer visited the ward each Monday evening. They carried out a quiz.

Meeting the needs of all people who use the service

- The building was wheel chair friendly. We saw evidence of individual rooms to meet young people's particular needs. The rooms were age appropriate and comfortable.
- The information leaflets on display were in English only. Leaflets were available in other languages and staff could print these off if required.
- Young people were informed. We saw patient advice and liaison service (PALs) leaflets were available advising young people how to complain. Information on advocacy was available. Young people received an information pack on admission.
- One young person told us they did not eat meat or like Quorn (a meat substitute). Their likes had been acknowledged and addressed this meant the service met individual young people's preferences.
- Young people were encouraged to maintain contact with their friends. Two young people told us their friends had visited. This meant the young people maintained their existing networks whilst at the ward.

Listening to and learning from concerns and complaints

- The service had not received any formal complaints within the previous 12 months. The ward manager received feedback from the patient opinion website. There had been a recent communication error. This had been resolved informally.
- Young people knew how to complain. They said they would feel confident to complain. We saw PAL's leaflets available.
- Staff were aware of the how to deal with complaints and how to escalate concerns. A complaints book recorded informal complaints.
- Staff received feedback from complaints and investigations. We were given examples of changes made in response to feedback:
- Bedroom doors had been fitted with privacy windows to allow staff to observe young people without entering their bedrooms. Young people were now able to lock their bedroom doors. One young person had felt intimidated when attending for care programme approach meetings (CPA's). The team produced a booklet with a part for young people to write in which staff read out at CPA's.
- Young people had given positive feedback to the changes. This meant the team listened to young people and made changes and improvements.

Are services well-led?

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

Our findings

Vision and values

- The staff were aware of who the senior manager was for the service.
- Staff told us senior managers were approachable, supportive, and visible within the service. The modern matron, service manager, divisional manager, and deputy divisional nurse visited the ward to carry out spot checks. Student nurses said there was good visible leadership from managers.
- The ward values were to give evidence-based care to young people. A peer support worker was employed by the service. They were involved in the development of the service. This linked to the trust values of involvement and respecting people's values.

Good governance

- Staff received effective mandatory training. Staff monitored and planned updates. A fire alarm was accidently activated during the inspection and staff provided a good, timely response.
- Staff received regular support and supervision. Appraisal and development took place. Senior team members attended a leadership group. This was to provide governance to the service. This ensured lessons learned fed into team meetings, or if urgent, managers sent an e-mail to staff.
- Policies and procedures were in place to enable staff to work with young people. There were sufficient staff of the appropriate grade and experience.
- Staff were focused on direct care delivery. Student nurses told us the nurse in charge spent lots of time in communal areas.
- Incident reporting took place. Learning from incidents was evident.
- Staff knew their responsibilities in relation to the Mental Health Act and Mental Capacity Act. Staff knew how to keep people safe. Staff knew what constituted abuse and how to report this.
- The ward manager had the authority to adjust staffing levels to meet the needs of young people.
- The ward team had submitted items to the risk register. Staffing was on the risk register since 2014.

Leadership, morale and staff engagement

- Sickness and absence figures from April to July were 2% or below. This showed an improvement on previous months. For the previous eight months, they had fluctuated between 8% and 14%.
- Staff were aware of the whistleblowing process.
- Staff informed us they would be confident to raise complaints or concerns.
- Staff were aware of the duty of candour. Staff advised young people and their families if things went wrong.
- Staff reported they felt supported by their colleagues and management team. Staff said they were happy in their roles. They enjoyed their jobs and felt that stress was manageable. Staff felt they did a good job.
- Staff said they were happy working in the team. They felt communication was effective. We saw the team functioned well during our observations of a multidisciplinary team meeting.
- During team meetings, staff were able to give comments and suggestions for improving the service and delivery of patient quality care. This demonstrated effective MDT working.
- There were no current bullying or harassment cases in the team.
- There was an open culture within the team. Staff felt informed of incidents and new initiatives. However, a healthcare assistant did not receive updates on lessons learnt.

Commitment to quality improvement and innovation

- The service was working towards gaining the quality network for inpatient CAMHS (CNIC) accreditation. It was aware the current building would not allow it to achieve this. It was hopeful that once in the new built facility this would be achievable