Huntercombe Hospital - Maidenhead

Quality Report

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

Ratings

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

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

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

Summary of findings

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

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

Overall summary

We rated Huntercombe Hospital Maidenhead as good because:

- Processes were in place to manage environmental risks and the hospital complied with same-sex accommodation guidelines. Emergency equipment was available and checked regularly. Wards were clean and there were nurse call bells for patients and personal alarms for staff. Each nursing shift throughout the day and night was covered with qualified and unqualified staff and there was appropriate use of agency staff. Staff assessed risks and observed patients according to their risk. There were robust links with the local authority and staff were aware of safeguarding procedures. Following incidents there was good investigation and learning, and changes were made. Staff had processes in place to ensure that physical health needs were met.
- There was timely assessment of needs on admission. Medicines and therapy were provided as directed in NICE guidance. Staff used a range of evidence based psychometric tests and outcome measures. Staff received induction and training relevant to their roles and had access to a specialist training budget. They received regular supervision from their managers. We found there to be comprehensive, informative shift-to-shift handovers on all wards. Mental Health Act paperwork was in good order.
- Staff were caring, treated patients with dignity and respect and were knowledgeable of patients' needs. There was excellent involvement in hospital affairs and patients' views were sought and implemented regarding changes to the hospital.
- Transition options were available for patients to step up to a more secure ward or down to a ward with greater freedom dependant on risk. There were a range of facilities inside the wards and in the grounds. Patients were able to personalise their bedrooms. Activities were available throughout the week. Catering was provided and the team were able to cater for individual patients' ethnic or religious dietary needs. Complaints were dealt with appropriately and the provider fulfilled its duty of candour.
- The hospital management were visible and supportive to staff. There was oversight of performance through monitoring and review. The hospital responded to staff and patient needs from the results of questionnaires, user involvement groups and a staff forum. Communication from management had been improved with the addition of a newsletter. There had been a recent restructuring of the senior management team which had a positive effect on morale and teamwork.

However:

- Staff knowledge of the Mental Capacity Act was inconsistent and knowledge of Gillick Competency was poor.
- A decision had been made to allow staff to use a room for seclusion that did not comply with their own policy or the guidance in the Mental Health Act Code of Practice.
- We found that there were blanket restrictions on all of the wards rather than patients being individually assessed for restrictions.
- Staff did not consistently report all lower level incidents on the wards and tended to focus on recording incidents of restraint.
- Patients gave some negative comments about the night staff.
- There were mixed reports on the quality of the food.

Summary of findings

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Huntercombe Hospital Maidenhead

Services we looked at -
Child and adolescent mental health wards

Summary of this inspection

Background to Huntercombe Hospital - Maidenhead

Huntercombe Hospital Maidenhead is a specialist child and adolescent mental health inpatient hospital (CAMHS). It is a 60 bedded independent hospital owned by Four Seasons Ltd. It provides specialist mental health services for adolescents and young people from 12 to 25 years of age and is registered to treat patients who are detained under the Mental health Act 1983. It also has patients who are informal. Huntercombe delivers specialised clinical care for young people of both genders requiring CAMHS, including eating disorders.

The hospital and its surrounding grounds are within a rural setting and are situated near a town with easy access to transport links and shops. In-house sports and social facilities include a gymnasium, an enclosed garden and asports area. Patients are supported in their education via the hospital school. Where appropriate the patients have access to the hospital grounds and local community facilities.

The hospital consists of four wards, all wards are mixed gender:

• Kennet ward provides eating disorder services and has 20 beds.

• Tamar ward provides Tier 4 CAMHS general adolescent services and has 11 beds.

• Thames ward with 14 beds and Severn ward with 15 beds provide psychiatric intensive care services (PICU).

The hospital was previously inspected in December 2014 as part of the pilot for Care Quality Commission's new inspection methodology, it was therefore not rated. The previous inspection report was positive about care at the hospital but found there was some action for them to take around patient risk assessment. The compliance action related to a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) This meant that the hospital had to ensure that risk management plans were clear and updated regularly, when new risks were identified. Following this inspection we were satisfied that improvements had been made and the compliance action had been met.

Our inspection team

Team leader: David Harvey, CQC Inspector.

The team that inspected the service consisted of three CQC inspectors, an inspection manager, a mental health act reviewer and two specialist advisors with experience in CAMHS services.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Summary of this inspection

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

During the inspection visit, the inspection team:

- visited all four wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with the hospital director and registered manager
- spoke with 23 patients who were using the service
- looked at 35 care and treatment records of patients
- spoke with the managers for each of the wards
- spoke with 19 other staff members; including doctors, nurses, occupational therapists, occupational therapy assistants, support workers and support worker managers
- spoke with a social worker, lead nurse and a drug and alcohol worker
- received feedback about the service from advocates and commissioners
- attended and observed three hand-over meetings, activity groups and two multi-disciplinary meetings
- reviewed employment records, serious incidents, complaints and training records
- carried out a specific check of the medication management on all wards
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

- Patients gave mixed reports about how staff treated them. Some patients felt cared for, reported staff were friendly, and that they were included in decisions about their care.
- Nurses knocked before entering their rooms and knew patients preferred names.
- Staff were respectful. One patient stated that you could tell the staff cared, as they gave time when it was needed and another patient stated that staff went the extra mile. The 2015 CAMHS patient experience questionnaire showed that 85% of patients felt supported by staff when they needed help and 81% felt that staff treated them with dignity and respect.
- However, we heard from some patients that they felt poorly treated by certain staff. Several patients reported that the night staff were rude, often talked in their own language, were noisy and fell asleep on observations. The issues with night staff had been raised in the user involvement group and ward managers were aware and taking action to resolve this.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

- Wards were clean and tidy and staff had assessed the environment for risks, and were aware of risks from ligatures. All wards were mixed gender and consideration was given to gender separation.
- The resuscitation equipment and emergency drugs were checked regularly. Staff complied with infection control procedures, two staff had been trained to lead on infection control.
- Shifts were covered by qualified and unqualified staff. Agency nurses were known by the hospital and booked appropriately. There was enough staff to monitor physical health and to undertake physical interventions. A consultant psychiatrist was on call to provide out of hours medical cover.
- Staff assessed patients' risks on admission, at regular intervals, and following an incident. Patients' rights were explained to them regularly. Observations were prescribed according to risks and these were reviewed by staff regularly. Care plans were created for when to administer 'as required' medications. This meant that staff were well informed of a stepped approach to managing patients' mental state with medication.
- Review of seclusion was in line with the hospital policy. Staff created reintegration plans for the patient in seclusion and there were efforts made to discontinue seclusion.
- Staff received training in safeguarding and were knowledgeable of the procedures relating to these. A safeguarding lead for the hospital had oversight of safeguarding and there were good links with the local authority.
- Incidents of restraint were recorded. Serious incidents were investigated and there were changes made as a result. A safety and governance meeting had been set up to share and discuss individual incidents.

However:

- A decision had been made to use an en-suite bedroom on Thames ward as seclusion room. The room did not comply with the guidelines set out in the Mental Health Act Code of Practice or the hospitals own seclusion policy.
- Staff were underreporting incidents on the wards with the focus of incident reporting on incidents of restraint. Hospital management had increased staff training to address this.

Summary of this inspection

- While it was clearly documented when patients had refused physical health monitoring following rapid tranquilisation we found that staff monitoring for patients following rapid tranquilisation was inconsistent.
- We found that there were blanket restrictions on all of the wards such as locked toilets and lounges, therefore restrictions were not put in place according to individual patient need.

Are services effective?

Requires improvement

- Staff knowledge of the Mental Capacity Act was inconsistent and there was poor understanding of Gillick Competency. Gillick Competence is a test in medical law to decide whether a child of 16 years or younger is competent to consent to medical examination or treatment without the need for parental permission or knowledge. Particularly on Kennet ward there was a tendency to consider under 16's to need parental consent rather than assessing capacity to gauge whether the patient was able to consent for themselves as Gillick Competent.
- We found instances where medication had been prescribed and administered without it being included on the accompanying T2 or T3 document. Form T2 is a certificate of consent to treatment completed by a doctor to record that a patient understands the treatment being given and has consented to it. Form T3 is a document completed by a second opinion appointed doctor to record that a patient is not capable of understanding the treatment he or she needs or has not consented to treatment, but that the treatment is necessary and can be provided without the patient's consent.
- We found that care plans were often instructional towards staff rather than written in the patients' voice.

However:

- Patients' needs were assessed on admission. Physical health and food and fluid intake was monitored. Staff completed care plans for a range of needs.
- Medication and therapy was provided as guided by the National Institute for Health and Care Excellence (NICE). There were a range of therapies provided by therapy staff. Staff used psychometric testing and outcome measures.
- Staff engaged in clinical audits and made changes to their practice based on the outcomes. The eating disorder service had been audited against NICE guidance and found to be compliant.
- Induction processes were sound and there was induction based on the care certificate. Staff received regular supervision

Summary of this inspection

from their line manager. Poor staff performance was addressed appropriately. There was separate management of support workers meaning supervision that was given by nurses in the past was now provided by support worker managers.
- Patients were reviewed weekly by the multidisciplinary team. There was comprehensive shift-to-shift handover on all wards. Care Programme Approach (CPA) meetings took place six weekly with the inclusion of community teams and families.
- Mental Health Act documentation was in good order.

Are services caring?

Good

- Staff were knowledgeable of patient needs, interacted well and treated patients with dignity and respect. Patients reported that staff were caring.
- Patients were oriented to the ward on admission and were designated a key worker and co-keyworker.
- An independent mental health advocate visited the hospital weekly.
- Families and carers felt the hospital was compassionate and that patients were well looked after. There was a bi-monthly family and carers day so that they could meet staff and ask questions about the care provided.
- Staff facilitated a user involvement group which allowed patients to make changes around the hospital. Participation in the 'glamour your manor' scheme had given patients the chance to request and get an all-weather sports pitch, gazebo and outdoor furniture budgeted and planned for by themselves.
- The hospital organised an annual fete for discharged patients to come back and show staff and patients how they were progressing in their recovery. This was an incentive for current patients to recover and for them to see the face of recovery.

However:

- We heard negative reports from patients about the conduct of some night staff.
- Some families and carers reported that they were not always informed of treatment decisions.

Are services responsive?

Good

- The hospital provided staff to take and support patients on community and home leave. There were hospital cars available to enable this.
- There was the option for patients to move through the hospital dependent on their needs.

Summary of this inspection

- There were a variety of clinic and treatment rooms. There was a well-equipped school that was registered with Ofsted. There was a large amount of outside space for all wards including secure gardens for Thames and Severn.
- Patients were allowed to personalise their bedrooms, they had access to a lockable safer storage area for personal belongings.
- Staff provided a range of recreational and therapeutic activities throughout the week and weekends. These were based both on and off the wards.
- A welcome pack containing information about staying in the hospital was given to all patients on admission.
- The hospital provided Skype and FaceTime so that patients could contact their families and carers. It was also used to help families and carers take part in care programme approach (CPA) meetings if they were unable to attend.
- The catering team catered for patients differing diets based on personal dietary choices and their cultural or religious needs.
- Complaints were reviewed effectively, and learning was shared with staff teams.

However:

- There were varying reports on the quality of the food.

Are services well-led?

Good

- The hospital was well-led and the management were visible and known throughout the hospital, Regular drop-in sessions were provided to meet the hospital director and registered manager.
- The hospital management had good oversight of performance through auditing. Staff numbers were adjusted according to changes in need. Demand on the service was monitored through a dashboard.
- The induction process had been changed so that new staff started together and mandatory training was delivered in a block session.
- The hospital was seeking to improve its risk assessment process by looking at best practice in other services.
- Following challenges posed by their new incident reporting system it was re-launched with increased training to improve practice.
- Risks throughout the hospital were inputted and managed through a risk register.
- Sickness levels were low, staff were aware of the whistleblowing process. Staff felt supported by their line manager.

Summary of this inspection

- There was communication from senior management through a monthly newsletter and organisational health posters.
- There was commitment to quality improvement by internal and external review.

However:

- Staff we spoke with were not always aware of the hospital visions and values but as they were working within the stated values this did not have an adverse impact on patients.

Detailed findings from this inspection

Mental Health Act responsibilities

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

- Staff received joint Mental Health Act (MHA) and Mental Capacity Act (MCA) training. The hospital completion rate for doctors and nurses was 62%. Staff were knowledgeable about the different sections of the MHA and the restrictions that applied in practice.
- MHA oversight was by a mental health act administrator who also completed audits of the paperwork. We found evidence that paperwork was kept in good order, was complete, up to date and stored appropriately.
- Many of the patients were treated under parental consent rather than the individual consent of the young person. All care records documented who gave consent to treatment. Many of the patients who were treated under parental consent were treated on the eating disorder programme. Many of them had been assessed as not able to consent to treatment for their eating disorder. Therefore their parents had consented to the treatment.
- Young people who were detained under the Mental Health Act were informed of their rights in accordance with the Code of Practice. There were signs up asking informal patients to speak to a nurse if they wanted to leave the ward and staff explained this would be risk assessed on an individual basis.
- Medication was generally given in accordance with the consent to treatment provisions of the MHA and Code of Practice. However, we found instances where medication had been prescribed and administered without it being included on the accompanying T2 or T3 document. Form T2 is a certificate of consent to treatment completed by a doctor to record that a patient understands the treatment being given and has consented to it. Form T3 is a document completed by a second opinion appointed doctor to record that a patient is not capable of understanding the treatment he or she needs or has not consented to treatment but that the treatment is necessary and can be provided without the patient's consent.
- The decision to use inappropriate facilities for seclusion did not comply with the guidance in the Mental Health Act Code of Practice. However, we found evidence of robust reviews of seclusion taking place and plans for reintegration to the ward.
- Independent Mental Health Advocacy was provided by an independent advocacy charity.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff received joint Mental Health Act (MHA) and Mental Capacity Act (MCA) training. The hospital completion rate for doctors and nurses was 62%. An annual e-learning module on the MCA had been introduced in 2015 and had achieved a completion rate of 64%.

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. Staff had varying degrees of knowledge of the MCA. Some staff we spoke to were not conversant with the principles of Gillick and particularly on Kennet ward there was a tendency to consider under 16's to need parental consent rather than assessing capacity to gauge whether the patient was able to consent for themselves as Gillick Competent. Of the 17 records reviewed we could find no rationale or assessments relating to the capacity of young people to make decisions about their care.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Good

Child and adolescent mental health wards

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

Are child and adolescent mental health wards safe?

Good

Safe and clean environment

- Kennet Ward was set inside the manor house at Huntercombe Hospital. The house was a grade 1 listed building which meant the provider had limited options to adapt the building. As a result there were not clear lines of sight down the corridors and bedrooms were situated at varying levels. This meant that staff were not able to observe all parts of the ward. Tamar Ward was situated in a grade 2 listed building across a court yard from the manor house. There was CCTV to observe parts of the ward but staff were not able to have clear lines of sight due to the nature of the ward being set over two floors. Despite the issue with lines of sight, staffing levels and observations mitigated these risks. Thames and Severn wards were in a purpose built building to the side of Tamar. Thames had two large areas that could be zoned to separate to male and female bedroom areas while Severn ward had bedrooms off a main corridor and a separate annexe for patients that needed to spend time in a quieter area. Both wards had lines of sight that made it easier for staff to observe larger parts of the ward.
- Assessment 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. Wards were fitted with anti-ligature fittings such as door handles and collapsible curtain rails. Identified ligature points were recorded on the environmental risk assessment and staff were aware of how to manage the risks. Ligature cutters were available at several points around each ward and handovers covered what to do in the event of a ligature incident.
- All wards were mixed gender and complied with same sex accommodation guidance. Staff were able to separate bedrooms according to gender mix. There were identified female lounges and toilets and bathrooms were designated according to gender. Thames had one en-suite bedroom and Severn had four. We found consideration given to the availability and mix of staff to ensure that care was given by someone of the same sex if needed.
- Each ward had resuscitation equipment, emergency drugs and oxygen available to staff in the event of an emergency medical situation. These were kept in the staff office and checked at the start of each shift to ensure that items were working and in date. There were fully stocked clinic rooms on each ward that held medication, protective equipment such as gloves and syringes and a medication fridge which was checked regularly by staff. Equipment to measure blood pressure, height and weight was available. However, we found that there was only one examination couch in the hospital situated in the manor house near Kennet ward. Staff told us that the doctor would therefore examine patients in their bedrooms or in the doctor's offices.
- There were no dedicated seclusion rooms in any of the four wards. A decision had been made to use the en-suite bedroom on Thames ward as a seclusion room in order to manage risk. This room did not comply with the Mental Health Act Code of Practice on seclusion rooms. Staff were guided to use this room as 'open seclusion' where the door would remain open but three members of staff would stop the patient from leaving, as

well as having the door shut to contain the patient at other times. The bed was not visible from the viewing panel in the door and the bathroom was not in a position where staff could easily observe a patient using it, without entering the bedroom. We found that the room had only been used to seclude one patient, regular reviews took place by both the medical and nursing team and the local authority safeguarding team were notified of the use of the room. There was a clear rationale in the notes detailing why the patient needed to be nursed in seclusion, and there had been attempts made to end seclusion however the decision to use a room which was not fit for purpose had potentially put staff and the patient at risk and there had been assaults on staff. This patient had been referred to another hospital which was more suitable for their needs and was waiting for a bed to become available. Hospital management gave assurances that this room would not be used for seclusion in the future, and plans were in place to develop a seclusion room within the extra care area on Severn ward.

- We found the wards were cleaned and well furnished. Severn, Tamar and Thames appeared tired in places however, they were generally well maintained. Reports from patients at Kennet Ward at the time of the inspection were that the unit was dirty and in need of redecorating. However, results from the patient experience questionnaire showed that 83% of patients at Maidenhead had found the wards to be clean. We saw documented evidence that ward and communal areas around the hospital had been checked and cleaned regularly.
- Guidelines were available to staff around hand hygiene and all staff had received training in hand hygiene procedures. A recent infection control audit had identified areas of the wards that needed attention, for example, a build-up of lime scale around taps, areas with scuff marks and medical equipment had not always been cleaned. An action plan was developed as a result of the audit and a nurse and support worker had been trained in infection control in order for them to take the lead in implementing the action plan. There were regular meetings, where progress against the action plan was monitored.
- Call systems were available to patients to summon for staff assistance. These were situated on the wall in their bedrooms and at different areas throughout the wards. Staff carried alarms to summon help, these alarms fed into a display in the main areas of the ward so that staff could pinpoint the exact area where help was needed. There were plans to update this with a newer more robust alarm system. Staff checked alarms weekly.

Safe staffing

- Shifts throughout the day and night were covered with nurses depending on the needs of the patients. For example Thames and Severn had a minimum of one member of staff per patient which reflected the level of observations and risk that they were dealing with. Staffing numbers on top of this were adjusted according to increases in observations and we found that the wards were generously covered. Tamar and Kennet had lower staffing levels which reflected the need of the patients. There was always at least one qualified nurse on duty throughout the day and night with support workers making up the numbers.
- Ward managers reported staffing levels and the levels of observations via a daily shift report in order for senior management to gauge the level of need on the wards and supply staff accordingly. We found that generally when agency staff were used, they were familiar with the wards. The hospital used agencies that had trained their staff to an agreed level. The hospital had set up a pilot to offer additional shifts to their own staff, rather than contacting agencies. A text system had been put in place to text availability to staff. The result was a reduction in next-day agency shifts by 29% with 249 shifts going to their own staff.
- There had been previously been a high turnover of support workers. The hospital had gone from 40 support worker vacancies in September 2015 to -1.8 in January meaning they had over recruited into posts.
- The hospital had a sickness level of 3.% over the previous 12 months. There was 1.2 whole time equivalent (WTE) qualified nurse vacancies, one vacancy for a family therapist and there was locum cover for an associate specialist doctor vacancy.
- The staffing levels across the hospital meant that there were enough people to carry out physical interventions such as restraint. We found that when a ward was unsettled staff could call for assistance from other wards, using the radios to communicate.
- We found that patients were able to access a nurse easily with their presence visible on the wards. Staff told us that there were enough staff to provide 1:1 key worker sessions and we found evidence of these taking

place regularly in the notes. Activities were only ever cancelled due to either risk or a lack of interest. If there was staff shortage cover would be provided. We found that shifts were planned appropriately so that there was consideration given to external appointments. The hospital had a number of cars that meant patients could be escorted home if the family were unable to collect them.

- Medical cover was provided by a consultant psychiatrist for each ward, there was an associate specialist doctor available and out of hours, there was medical cover with a doctor on call. Staff were able to call on a local GP service to provide general physical health support and monitoring.
- A recent overhaul of the staff induction process meant that staff would receive a week of mandatory training in their first week of employment. This system meant that start dates could be synchronised and all employees would receive necessary training, in areas such as intermediate life support, child protection, health and safety and Control of Substances Hazardous to Health (COSHH). This induction programme had achieved a completion rate of 86%. We found that training in the Mental Capacity Act, Fire Evacuation & Safety, Manual Handling Practical and Breakaway were below 75% completion

Assessing and managing risk to patients and staff

- There was one episode of seclusion in the previous six months that occurred on Thames ward. Information provided prior to the inspection showed that there had been 490 incidents of restraint in the six months of May to October 2015. Of these, 240 were on Thames and 188 were on Severn, this included protective holds where staff would prevent a patient from self-harming. Staff did not use prone restraint in their practice (prone restraint is when a person is restrained face down on the floor).
- Staff assessed the risk of patients on admission using a risk screening tool contained in the electronic record system. We found that this risk assessment was regularly updated by the multidisciplinary team (MDT) in the patient's clinical team meeting (CTM). Staff were knowledgeable of patient risk and risk was discussed in handovers as well as throughout the shift. Risk assessments were updated following incidents. Risk assessment was uniform across the four wards and often the assessment linked into specific care plans. The hospital had been found as needing improvement to its process and documentation of risk in a previous inspection. It had therefore looked at best practice in risk assessment to inform its current practice. It had identified the risk management approach used by an NHS Trust as a basis to improve their practice further. There was a separate specialist risk assessment for eating disorders.
- We found that blanket restrictions were in place across the hospital. For example on Kennet, Severn and Thames wards all toilet doors were locked and on Severn and Thames lounges were locked when not in use. Staff stated that due to the nature of the patient group it was necessary to impose these restrictions particularly to reduce the risk of purging behaviours among patients with eating disorders. We found that patients were not able to progress past 15 minute observations whilst staying at the hospital. Therefore patients that had previously been on home leave and experiencing a greater liberty, were then restricted when they returned to the hospital. This approach was not considerate to the patient's recovery and impacted on a patient's privacy and dignity.
- Patients' rights were explained to them regularly if detained under a section of the Mental Health Act and there were signs up in wards areas explaining about a patient's right to leave if they were informal. This information was also in the patients admission information pack. Doors were locked to restrict movement into and out of the hospital. Staff explained that if a patient wanted to leave the hospital and they were informal they would discuss this with the patient, assess risk and if appropriate offer to have a member of staff accompany them, particularly for younger patients.
- The level of observation was determined by the risk posed by the patient and where they were in their recovery. Nurses were able to increase observations, but only a consultant was able to reduce the level of observations. We found that on Severn and Thames there was use of observations that meant a patient was supervised by between one and three members of staff at all times. Observation levels for constant supervision were documented on an 'Enhanced Observation Prescription Form'. This form guided staff on the level of observations, reasons for the enhanced observations, documented risks staff should be aware of such as deliberate self-harm and what level of privacy the patient should have, for example, whether they should be supervised in the toilet or bathroom. Enhanced

observations were reviewed by the team daily and documented on the form. This form was shared with the business administrator and clinical services manager due to the enhanced level of observations often requiring an increase in staffing levels. We found that observation levels were reviewed regularly and that there was discussion in handover and with the multidisciplinary team (MDT) about actively trying to reduce observation levels. Morning handover was an opportunity for nursing staff to inform the next shift about the levels of observation and what risks the staff members would need to be aware of.

- Staff were trained in Protecting Rights in the Care Environment (PRICE) in order to safely physically restrain patients. PRICE techniques were only used as a last resort. Staff actively engaged with patients, knew their risks and attempted verbal de-escalation through 1:1 rather than use restraint. There had been incidents of restraint multiple times on the same patients due to their behaviour.
- Rapid tranquilisation was used throughout the hospital both orally and by intramuscular injection (IM). This was only used as a last resort when other less intrusive options had failed such as 1:1 time and distraction techniques. Staff formulated a care plan for as required (PRN) medication. The care plan, called the PRN Algorithm, stated short and long term goals for using PRN. This was a stepped approach, instructing use of de-escalation techniques as a first line of treatment, using oral as the second line of treatment and then IM as the third line. It also instructed staff what medication to use first if the decision was made to medicate. Staff did not always consistently complete physical observations following IM medication as directed by the National Institute for Health and Care Excellence (NICE) guidance – Violence and Aggression: short term management in mental health and community settings. In some cases it was documented in the notes that physical monitoring was refused. In order to improve consistency a staff member and a pharmacist had created a new form , which clearly set out NICE guidance for documenting physical health post IM, this was in the early stages of being implemented. The form guided staff on when to increase observations for example if the patient had taken illicit drugs or alcohol or had a pre-existing physical health problem. It provided guidance on normal ranges for blood pressure, respiratory rates, and temperature with written advice to contact the doctor if the patient was outside these ranges.
- 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. Staff reviewed seclusion and documented these reviews in accordance with their policy and in line with the Mental Health Act 1983 Code of Practice. The rationale for seclusion was clearly stated in the notes as to why it was considered least restrictive option and in the best interests of the patient. A care plan for seclusion was completed which set goals for the patient, for example, to reduce deliberate self-harm and for reintegration onto the ward. Regular reviews were documented by both nurses and doctors with evidence that attempts had been made to end seclusion. This ensured that the secluded patient was regularly reviewed and not secluded for longer than was necessary, in accordance with the Mental Health Act 1983 code of practice. Staff documented observations in a contemporaneous record of mental health and behaviour while maintaining on-going physical health monitoring. However, we found that there continued to be assaults on staff during the episode of seclusion,. The lack of appropriate facilities around the environment of the room used for seclusion, meant that neither the staff nor patient's safety was protected despite the aim of the seclusion being to reduce the risk of harm.
- Staff received training in safeguarding adults at risk and child protection and knew how to identify safeguarding issues. Staff were knowledgeable about safeguarding procedures and there was good oversight from a safeguarding lead, who was a social worker. There was a safeguarding nurse and a lead doctor for safeguarding. The safeguarding lead checked with the wards regularly to identify safeguarding issues and if any incidents warranted an alert to be raised. A flow chart was on display in ward offices to remind staff how to respond to a safeguarding concern and all knew how to complete documentation if disclosures were made. There were good links with the local authority and where action was needed there was evidence that the staff at the hospital worked in conjunction with the local authority to safeguard patients. A spreadsheet of all safeguarding alerts made was held by the safeguarding lead and reviewed regularly.

Good

Child and adolescent mental health wards

- Medicines were stored appropriately in clinic rooms. Staff checked controlled drugs regularly and monitored the temperature of the medicine fridge and the clinic room. Pharmacy provision was supplied by an external company who delivered medication daily. The pharmacist attended weekly to conduct a prescription chart audit on each ward. Staff kept photos of patients on the medicines charts and allergies were written on the front. Staff received training in medicines management via e-learning. Ward managers completed audits of medication charts to ensure there were no discrepancies, for example checking to see all medications had clear dose, route of administration, form and instruction. An action plan was put in place to address discrepancies on charts before being re-audited.
- Visitor's rooms were available for family visits for all wards. Both Thames and Severn wards had visitor's rooms accessible from the wards but were lockable to allow children to visit.

Track record on safety

- Over the previous twelve months there had been six serious incidents requiring investigation (SIRI) and two serious incidents requiring review (SIRR). The SIRI's included attempts to abscond and incidents of self-harm leading to serious injury. One of the self-harm incidents involved a Control of Substances Hazardous to Health (COSHH) incident, where a patient ingested cleaning chemicals obtained from the cleaning trolley. The SIRI was reviewed and discussed in the clinical governance and senior management team meetings and also in the health and safety meeting. As a result of this incident COSHH items used by cleaners on wards were kept in locked containers to make it more difficult for patients to access them.

Reporting incidents and learning from when things go wrong

- The hospital had moved from a paper-based to an electronic incident management system, Datix. Datix allowed management to centrally monitor and manage incidents while allowing it to recognise trends and feedback learning to the original reporter. Staff were trained in Datix, however, since its implementation in 2015 there had been challenges in embedding it effectively, it was noted by hospital management that out of 156 incidents reported 126 of these involved restraint. The senior management team felt that staff were therefore not reporting lower levels of incidents such as verbal aggression and this was being addressed with staff teams. As a result, the hospital re-launched Datix in order to focus on good practice in the reporting of incidents. More training was being provided for staff in order to raise awareness of what should be reported.
- At ward level incidents were discussed in the morning multi-disciplinary team (MDT) handover and whether an incident had been recorded on Datix was addressed. The MDT reviewed incidents weekly in the Clinical Team Meeting and this was documented in the patients' notes. More uncommon incidents were reviewed weekly in the safety and governance meeting, in order to share thinking and for staff to look for advice. The minutes were cascaded to ward managers to share outcomes with staff. Lessons learnt had been implemented following incidents, for example on Tamar ward following a patient's money and property going missing the safe had been moved so only nurses had access and zip lock bags were being purchased.
- Staff received de-brief but not after every incident, they were given time off of the ward following restraint if they needed it. Staff stated that at times senior management attended the ward following an incident in order to offer their support.

Are child and adolescent mental health wards effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- Medical staff completed an initial history, mental state and physical health examination on admission. A routine blood test and electrocardiogram (ECG) was conducted for all new eating disorder patients. Consent was sought and observations agreed upon. There was on-going assessment of mental and physical health by nursing staff which helped formulate care plans. An initial care plan was completed upon admission before more detailed care plans were completed.
- Staff monitored physical health completing vital signs weekly or more often if prescribed. Food and fluid intake

was monitored for patients with an eating disorder. Physical health care plans were in place when needed to manage eating disorders or for monitoring clozapine for example.

- We reviewed 35 sets of care records across the four wards, including the electronic records on the patient information system Care Notes. We also looked at the accompanying paper files. Staff completed care plans to manage the risk and care of patients. A variety of care plans were in place such as risk related behaviour, occupational therapy, likes & dislikes and exercise and healthy eating plans. There were a number of standardised care plans found in the hospital, for example sleep hygiene, discharge and leave of absence care plans. There was clear patient involvement in the care planning process for a number of the care plans we reviewed, but this was inconsistent across the hospital. Staff documented whether or not a patient had been offered or accepted a copy of the care plan. Patients stated that they did feel involved in decisions about their care and patients' views were included in some form even on the standardised plans.

Best practice in treatment and care

- Staff followed the National Institute for Health and Care Excellence (NICE) guidance, such as the guidance on 'depression in children and young people: identification and management', when planning the treatment and care for patients. For example, medication was prescribed in conjunction with psychological therapies such as individual therapy and family interventions. PRN medication was prescribed in accordance with the guidance on violence and aggression. Care plans were implemented appropriately to reflect NICE guidance, which was linked to the website. The eating disorder service, Kennet, had been reviewed against NICE guidance and was found to be fully compliant. The self-assessment of Kennet in the Quality Network for Inpatient CAMHS (QNIC) had referenced NICE guidance regarding its provision of therapies in conjunction with medication. For example the notes showed us that doctors reviewed medication weekly and we found that changes had been made through the physical monitoring of patients.
- The hospital employed psychologists, family therapists, occupational therapists and occupational therapy assistants and an art therapist. A dietician was employed to provide support for those with an eating disorder. There was a total of 14 staff in the therapies team which was led by a Head of Therapies who was also a member of the senior management team. We found evidence that a range of therapies such as cognitive behavioural therapy (CBT) and dialectical behaviour therapy (DBT) offered by the therapists on a 1:1 and group basis. Psychologists were assigned to individual wards rather than throughout the hospital as had previously been the case.
- An external GP provided general physical healthcare for patients and visited the hospital weekly with all wards able to book appointments. Staff were able to take patients to the GP surgery if needed outside of the weekly visit. An associate specialist doctor completed blood tests and ECG's on admission and when required throughout a patients stay.
- Staff used the recognised rating scales Health of The Nation Outcome Scale Child and Adolescents (HONOSCA) and Children's Global Assessment Scale (CGAS) throughout admission to assess and record severity and outcomes. Staff used the Connors-Wells self-report scale to help recognise problem behaviours associated with Attention Deficit Hyperactivity Disorder. Psychologists used the psychometric testing Beck Youth Inventory (BYI) to evaluate patients emotional and social functioning with every patient. Staff on Kennet ward completed the Eating Disorders Examination Questionnaire (EDEQ) for all patients admitted. The EDEQ concerns the frequency in which the patient engages in behaviors indicative of an eating disorder over a 28-day period. The completion of the EDEQ was included in the Commissioning for Quality and Innovation Framework (CQUIN) to collect outcomes for patients with an eating disorder. The CQUIN payment framework enables commissioners to reward excellence by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals. Throughout the 2014/15 contractual year the hospital had achieved 87% completion in EDEQ.
- Staff engaged in a mixture of clinical and management audits on a wide range of topics. This included, medicines, Mental Capacity Act (MCA) Mental Health Act (MHA), supervision, outcome measures and infection control. Staff audited risk assessments and care plans to ensure quality and completion. Audits were conducted by ward based nursing staff as well as management. We found evidence that when an audit tool was not

available, for example, for safeguarding, it was discussed in the senior management team meeting so that the required staff would do a self-check. Staff completed environmental clinical checks monthly. Regularity of 1:1 key worker sessions was audited to ensure that patients were receiving weekly 1:1 sessions with their designated key worker. Outcomes of these audits were documented and action plans put in place to ensure improvement in practice. The hospital had identified that there had been gaps in documenting these sessions. Since the audit had been done and action taken, there had been significant improvement in this area. We saw notes that showed us that 1-1s were regularly documented. An audit committee was in place to ensure that audits were of good quality, contained robust action plans and were completed on time. This then fed into the clinical governance meeting.

Skilled staff to deliver care

- Staff from a range of backgrounds provided the care for the patients at the hospital. There was a mixture of nursing, therapeutic and medical disciplines making up the MDT who all played a part in supporting a patient's recovery. Each ward had a dedicated consultant and every patient was appointed a key worker and co-key worker. Support workers were employed to aid the running of the ward and support the nursing team. There was great value placed in support workers throughout the hospital and it was a role that was being developed further. There was a senior nurse in place to provide nursing leadership and to develop the current nursing team and to embed good practice. Occupational therapy and a therapeutic activity timetable were provided with support from occupational therapy assistants. A drug and alcohol worker provided substance misuse focussed group work.
- Staff received induction in the hospital using a welcome pack, induction checklist and induction training. Staff were given a clinical induction pack introducing hospital policies and procedures, helping staff understand their role in keeping patients safe and well. Support workers had an induction based on the Care Certificate to provide more structured learning and a qualification for support workers. This certificate needed to be completed in the first 12 weeks of employment. A senior support worker role had been developed to provide career development for support workers. This helped to improve the capacity of the workforce and these senior support workers provided mentoring for new starters and helped to free qualified nursing staff. There was a training budget for staff to request specialist training for professional development. Senior staff and nurses were able to access specialist leadership training.
- Staff received regular supervision every six weeks. Hospital management had recently recruited two support worker managers to provide supervision and to aid the recruitment of support workers. These support worker managers provided supervision during the day and night in order to provide support for all support workers rather than relying on nursing staff to provide supervision that often got missed. An audit of supervision found that all nurses had received supervision in the previous six weeks and only three out 141 support workers had not received supervision in the same period. Of these three, two were on night shifts and one was on annual leave. An action plan had been put in place to ensure that the remaining three had been supervised by the end of February 2016. All therapy, medical, management and admin staff had received supervision six weekly. Therapy staff facilitated a weekly reflective practice group. Staff received a yearly appraisal.
- We found evidence that concerns with staff performance had been addressed; for example if there was poor quality agency staff then this was raised with the agency and the individual was not booked again. There were other examples of managers taking action where this was needed.

Multi-disciplinary and inter-agency team work

- Ward consultants facilitated the clinical team meeting (CTM) once weekly. The CTM was an opportunity for professionals involved in the care of the patient to discuss progress. This was done with patients and together care plans were put in place. Staff comprehensively reviewed risks, observation levels, mood, behaviour, incidents, family contact, medication, interactions and group activities, sleep and diet and weight. This holistic approach was complemented by input from the psychologist involved. Patients attended the CTM and were given the opportunity to ask questions and be included in the decision making. Staff gave patients a 'what I want to say at my CTM' form to

write questions they wanted to ask the team. Actions and outcomes were documented and evidenced progression, for example, observations being reduced and home leave being agreed.

- Staff conducted shift to shift handovers led by the nurse in charge. The handover was comprehensive and structured, giving a summary of all risks that staff needed to be aware of for each patient. Staff communicated sensitive personal issues such as bathroom privacy, reasons for observations, compliance with medication and physical health issues. The nurse handing over reminded staff of generalised practice such as maintaining patient dignity, the procedure for managing people tying ligatures, checking patients have swallowed meds. Following on from this handover there was an MDT handover for the medical and therapeutic staff.
- Staff throughout the hospital ensured there was care planning with external agencies such as community mental health teams. Six weekly Care Programme Approach meetings took place and always included the patient's community team. If an external agency or patient's family member was not able to make the meeting in person then there was the possibility of using Skype.

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

- Staff received joint Mental Health Act (MHA) and Mental Capacity Act (MCA) training. The hospital completion rate for doctors and nurses was 62%.
- MHA oversight was kept by a mental health act administrator who also completed audits of the paperwork. We found evidence that paperwork was kept in good order, was complete up to date and stored appropriately.
- All patients under the age of 16 were treated under parental consent rather than the individual consent of the young person. All care records documented who gave consent to treatment. Many of the patients who were treated under parental consent were on the eating disorder programme and many of them had been assessed as not able to consent to treatment for their eating disorder. Therefore their parents had consented to the treatment.
- Young people who were detained under the Mental Health Act were informed of their rights in accordance with the Code of Practice. Informal patients were informed of their right to leave the ward. Staff explained that if a patient wanted to leave the hospital and they were informal they would discuss this with the patient, assess risk and if appropriate offer to have a member of staff accompany them, particularly for younger patients
- Medication was generally given in accordance with the consent to treatment provisions of the Mental Health Act and Code of Practice. However, we found instances where medication had been prescribed and administered without it being included on the accompanying T2 or T3 document. Form T2 is a certificate of consent to treatment completed by a doctor to record that a patient understands the treatment being given and has consented to it. Form T3 is a document completed by a second opinion appointed doctor to record that a patient is not capable of understanding the treatment he or she needs or has not consented to treatment, but that the treatment is necessary and can be provided without the patient's consent.
- The use of inappropriate facilities for seclusion did not comply with the guidance in the Mental Health Act Code of Practice. However, we found evidence of robust reviews of seclusion taking place and plans for reintegration to the ward.
- Independent Mental Health Advocacy was provided by an independent advocacy charity.

Good practice in applying the Mental Capacity Act.

- Staff received joint Mental Health Act (MHA) and Mental Capacity Act (MCA) training. The hospital completion rate for doctors and nurses was low at 62%. An annual e-learning module on the MCA had been introduced in 2015 and had achieved a completion rate of 64%.
- Staff had varying degrees of knowledge of the MCA and in particular there was very poor understanding of Gillick Competency. Gillick Competence is a test in medical law to decide whether a child of 16 years or younger is competent to consent to medical examination or treatment without the need for parental permission or knowledge. Particularly on Kennet ward there was a tendency to consider under 16's to need parental consent rather than assessing capacity to gauge whether the patient was able to consent for themselves as Gillick Competent. Of the 17 records reviewed we could find no rationale or assessment of mental capacity.

Good

Child and adolescent mental health wards

Are child and adolescent mental health wards caring?

Good

Kindness, dignity, respect and support

- The 2015 CAMHS patient experience questionnaire showed that 85% of patients felt supported by staff when they needed help and 81% felt that staff treated them with dignity and respect.
- Staff interacted well with patients on the wards; they appeared to treat them with dignity and respect and provided both emotional and practical support. Staff engaged in activities on both a formal and informal basis. We found an impromptu knitting and crochet group taking place on Thames ward and there appeared to be the freedom for patients to request and engage in activities they wanted to do. Despite the complexity of patients at the hospital, many staff had been in post for a number of years and were dedicated. They engaged patients that were quieter and less confident than others and joined in general conversations about music and other interests.
- We heard staff talk about patient's personalities and personal aspects of their care. We observed comprehensive handovers and on the ward staff were sensitive to individual patient needs. We heard staff say things such as 'we never give up', that the patients were 'great' and that they loved their job. Staff appeared genuinely pleased when a patient had reached a milestone that meant they could go out on the trip.
- Patients had mixed reports about how staff treated them. Some patients felt cared for and that staff were friendly, they were included in decisions about their care. Nurses knocked before entering their rooms and they knew their preferred names. Staff were respectful and a patient stated that you could tell they cared, gave time when it was needed and another patient stated that staff went the extra mile. However, we heard from patients that felt poorly treated by some night staff. Several patients reported that the night staff were rude, often talked in their own language, were noisy and fell asleep on observations. Issues with night staff had been brought up in the user involvement group and ward managers were addressing these issues.
- The hospital had implemented the Friends and Family Test (FFT) which was a CQUIN but then built into their standard contract. The FFT was asked in 100% of discharges with 68% likely or extremely likely to recommend the service to a family or friend.

The involvement of people in the care they receive

- Patients reported that they felt involved in the planning of their care, but this was not consistently reflected in care plans, which often lacked patients views or a signature. It was not always clear when a patient had been given a care plan. Risk assessments were completed with the patient in the weekly Clinical Team Meeting (CTM). Patients were given the opportunity to be a part of CTM and able to have their say. The hospital had piloted the inclusion of patients in the CTM on Severn ward and due to its success rolled this out to Thames and Tamar wards. Patients on Kennet declined this approach and said they were happy with 1:1 feedback.
- An advocate visited the wards weekly and there was signage up in ward areas advertising the advocacy service provided by an independent advocacy charity. Despite having a presence on the ward there was an electronic referral system for advocacy as well as an informal point towards patients that might need advocate support. Prior to the inspection we gained feedback from advocacy who felt ward staff were extremely helpful and went out of their way to be supportive, staff were friendly and good care was given. However the hospital was not proactive in telling the advocate about care programme approach meeting dates.
- Staff stated families and carers were informed of progress in care following patient CTM's and when there had been an incident. Family therapy was provided and a new 'solutions focussed' approach had been developed for families to support patients with an eating disorder post discharge. Families we spoke with felt the hospital was compassionate, there was access to therapy, patients were looked after and that the hospital went above and beyond the call of duty. Some reported regular contact from the consultant, however, this was not consistent and we found that decisions about treatment and changes in condition occurred without families knowing. There was a bi-monthly psycho

Good

Child and adolescent mental health wards

education group for families and there was a family and carers day, so that families and carers could meet staff and other parents to ask questions about the care and treatment available.

- Staff held a community meeting each morning to plan the day on the ward and inform the patients what activities were being provided. Patients facilitated weekly community meetings on the wards as an opportunity to provide feedback about the service and to engage in discussion about what could be improved. The meeting was attended by members of the MDT and followed a set agenda that included items such as feedback about staff, ward rules, complaints and reminded patients of their named key worker. Minutes of this meeting were kept on the wall in the patient lounge.
- Staff facilitated a user involvement group, which was a joint meeting between patients and staff from all wards in the hospital. This group was an opportunity for patients to request improvements and share experiences in the hospital, both good and bad. Requests from this group were considered and the hospital made appropriate changes when possible. For example; patients had requested new carpets in the lounges, the hospital therefore replaced all the carpets in all the lounges; patients said that they wanted a cooked breakfast at weekends, the occupational therapists had therefore begun buying ingredients for patients to cook their own breakfasts at weekends. Changes in the hospital were communicated to patients on 'You said, We Did' posters.
- Patients at the hospital had triggered large changes and improvements by taking part in the 'Glamour Your Manor' scheme. This scheme provided funding to successful applicants with a budget to carry out their improvement plans for the hospital. In 2015 the user involvement group had requested an all-weather sports pitch usable for football, basketball and other activities, planting for the gardens, sports equipment such as goal posts, picnic benches, tables and gazebos and a sensory room. The proposal was service user led and budgeted. The hospital won the money and made the improvements. Patients and families were asked what improvements could be made in the hospital in 2016. Plans for the Glamour Your Manor 2016, included securing funds to update the kitchen so that patients with an eating disorder could cook and eat with their families, improve parking facilities and installing better air conditioning in the Psychiatric Intensive Care Units.
- The hospital put on an annual fete in the grounds and invited ex-patients of the hospital back to attend. They felt it was an incentive for patients to come back and let the staff at the hospital know how they were doing and staff could hear about the care they provided in a more reflective way. Patients could also meet former patients and see recovery in action. The hospital provided a bouncy castle and put on a barbecue.

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

Good

Access and discharge

- Data submitted by the hospital prior to the inspection showed average bed occupancy of 88%. Both Kennet and Severn wards had bed occupancy of 85%, which shows that while there was a high demand for this service beds were available when needed.
- Patients were admitted to the hospital from across the country to be admitted to the hospital, staff often had to facilitate leave for patients. Staff therefore took patients to their homes using the hospital cars and we heard from parents who said the hospital had supported their child in building confidence to use the train. Staff did not admit other patients into those beds when patients were on leave. Therefore if there were issues whilst a patient was out on leave there was always a bed on their return.
- Due to the hospital providing step up and step down care there was the possibility that when patients health improved they could progress to one of the wards with less security. Equally there was the ability to move a patient to a Psychiatric Intensive Care Unit (PICU) bed if risks increased. Staff told us that commissioners were happy for patients to move through the hospital. Moves through the hospital only occurred when it was clinically justified but there were always attempts to move patients closer to home if they were not local.

- Referrals were considered on clinical grounds and the overall decision to admit was with the consultant psychiatrist, however, there was a full discussion within the MDT and the needs of the other patients was considered. Patients were usually admitted to the hospital during the day but if an urgent admission was needed this was facilitated. Kennet ward tried to admit only on a Tuesday but were able to accommodate admissions on a different day if needed. Discharge occurred at an appropriate time and was planned during the Care Plan Approach (CPA) process.
- Data submitted prior to the inspection showed that there was one delayed discharge due to the patient being over 18. The hospital had been working closely with commissioners to find an appropriate placement.

The facilities promote recovery, comfort, dignity and confidentiality

- The hospital had a variety of clinic rooms, therapy rooms, activity rooms and visitors rooms. There was a school that had been registered with Ofsted which included several classrooms with books, art equipment and computers. Wards had an occupational therapy kitchen for functional assessments, there was a pop-up sensory room and ample outside space. There were lounges with sofas and televisions.
- Staff oriented patients to the ward on admission, a key worker was designated and an admission pack given. The admission pack contained information on the running of the ward, meal times, medication times, patient rights, advocacy contacts and the role of staff members in the multidisciplinary team. We found the admission pack to be informative and easy to read
- Staff did not allow mobile phones onto Thames and Severn so provided a cordless phone for patients to use. Tamar and Kennet allowed mobile phones providing they did not have a camera.
- The hospital was set in 8-9 acres of grounds, most of which was accessible to patients. Access to outside space was restricted for patients on Thames and Severn but staff provided outside activities and stated that they tried to get patients outside in the garden as often as they could.
- Patients reported mixed feelings about the food on offer. There was a choice of food available and there had recently been a menu revamp at the request of patients in the user involvement group. Patients told us the food was getting better but that often they did not understand what was in the food provided, as there were obscure names for some of the dishes. Drinks and snacks were available at the request of patients. The 2015 Child and Adolescent Mental Health Service (CAMHS) patient experience questionnaire showed that only 45% of patients were asked about their views on the food, 89% felt they were given enough food and drink and 69% felt supported at meal times.
- Patients' bedrooms were personalised with posters on the wall and own bedding in places, a wall was painted with blackboard paint in each bedroom. Patients were able to personalise their bedrooms, Patients had access to their bedrooms throughout the day.
- Staff stored patients personal belongings in designated cupboards, belongings were inventoried on arrival at the hospital. Due to risk it was sometimes necessary for personal belongings to be moved and stored away for a short time. We found that when that happened items were stored safely, staff reported that they kept a record of what was kept in the store rooms.
- Staff facilitated a range of hospital and community based activities. A therapeutic timetable was in place for weekdays where structured psycho educational activities, coping skills, individual occupational therapy/ psychotherapy slots and general activity was intertwined with school. There were evening physical activity sessions such as yoga and Zumba and also a movie night. Weekend activity was timetabled and a separate half term timetable was put in place for each ward. Both term time and half term activities provided community visits such as cinema trips and library visits.

Meeting the needs of all people who use the service

- There were few adaptations for disabled people. There was a lift available in the PICU building but neither Tamar and Kennet were wheelchair friendly environments.
- There was information available to patients throughout the hospital and in the admission pack; staff were able to provide information on medication and treatments. Notices were up in the corridors of the wards advertising services provided for example advocacy. Patient rights were displayed on the walls of the wards as were processes on how to make a complaint. We found that on days where there was a Clinical Team Meeting there

was an order of patients to be seen displayed. Staff pictures and names were displayed, showing who was on shift that day and who their allocated key worker and co-key worker was.

- The hospital provided a tablet for Skype and Facetime for patients and families to keep in touch and for families who were a long way from the hospital to use for care programme approach (CPA) meetings. We found that when the use of these was agreed there was a care plan in place.
- On Tamar ward there was a board patients could use to reflect their mood if they did not feel confident approaching a member of staff. There were pictures and colours they were able to put up on the board that reflected how they were feeling and space to tell staff what sort of interaction would be helpful. For example the colour green and a smiley face indicated that they were feeling good whereas the colour red and a sad or angry face would show the opposite.
- The catering team were able to provide food depending on personal dietary choice or on religious need and were supplying halal meals to a patient. There was access to a prayer box and the hospital had links to local faith groups. There was access to an interpreter which needed to be arranged through the hospital social worker.

Listening to and learning from concerns and complaints

- Data provided prior to the inspection showed that the hospital had received 14 complaints over a 12 month period. Seven of these were on Severn ward, five on Tamar and two on Thames. Of the 14 complaints six were upheld with four of these six only partially upheld.
- We reviewed complaints made to the hospital and found that the hospital were transparent and acknowledged when they had made mistakes. Staff told us that patients knew how to complain, there was information available displayed on the notice boards. There was ward level focus on complaints which meant that complaints were dealt with in community meetings and the patients CTM to try and resolve issues early on.
- We found that following a complaint being made there was communication about investigation time frames with the complainant. When there was more time needed there was a letter sent asking the complainant for more time. We found evidence of change when formal complaints were upheld. For example, following a complaint regarding care for a patient with an Autistic Spectrum Disorder (ASD) there was ASD training implemented. Lessons learned were circulated by the investigating officer and added to the priority list in handover so that issues were discussed.

Are child and adolescent mental health wards well-led?

Good

Vision and values

- Hospital management was visible throughout the hospital, we found that senior managers spent time on the wards and were approachable. Staff told us that ward level managers and the senior managers had an open door policy. At the request of staff they introduced regular drop in sessions to meet with the Registered Manager and Hospital Director. We heard that over the past year where there had been a transition to new management that there had been a focus on communication and team-work. Staff found the management on the whole very supportive and knew who the senior management in the hospital were.
- Staff we spoke with were not always aware of the hospital visions and values but as they were working within the stated values this did not have an adverse impact on patients.

Good governance

- The management at the hospital had oversight of performance through regular review and monitoring as well as auditing of care notes for completion and quality. Numbers needed for shifts were fed back daily to the management so that staff could be provided when needed. Management kept records of bed occupancy, monitored sickness, annual leave, observation levels, agency usage and training as well as the staff needed for escorts. Incidents and complaints were logged and fed back to commissioners weekly. There was a weekly dashboard showing demand on the service.
- There were processes in place to ensure that staff received mandatory training and a recent change in structure of recruiting and starting new staff on the same induction date meant that mandatory training

could be given in one go. The introduction of training based on the care certificate for support workers was partly implemented to improve recruitment and retention. The new induction process involved all staff meeting the senior management team.

- We found evidence that shifts were covered generously with Psychiatric Intensive Care Unit (PICU) staffing being set at one staff member per patient minimum. The hospital ensured that staff were provided when needed.
- Following past action by the Care Quality Commission, regarding a lack of documented risk assessment, changes had been made to ensure that risk assessment quality and completion was improved. While on the inspection we found that there was strong evidence of risk assessment taking place and there were further plans to implement best practice using the work of an NHS trust as a basis for further progress. A senior nurse had been put in place to ensure best practice was embedded going forward.
- Management responded to complaints and the hospital fulfilled its duty of candour, staff issues were addressed appropriately and there was feedback through handovers and staff meetings about changes made through incidents and complaints. A new electronic incident recording system had been a challenge when first implemented so the hospital had taken the decision to relaunch providing more training to ensuring staff knew how it was best utilised. We found that there was good ward level knowledge of the use of this system. Safety and governance meetings had been started to review incidents and complaints
- There was comprehensive auditing taking place and there was evidence of change as a result of the audit process. We found that safeguarding processes were followed and there was good oversight of safeguarding and robust relationships with the local authority.
- There was an issue however with the management decision to allow the en-suite room on Thames ward to be used for seclusion. The decision had put the patient and staff at risk and as a result there was staff sickness due to assaults.
- The hospital held a risk register which was reviewed at the senior management team meeting. Items were able to be added to this according to risks at the time, risks were rated red amber or green in order of severity and there were plans to manage risk.
- Due to feedback from the staff survey showing that there was a lack of management capacity there was strengthening of the senior management team through the creation of a new hospital director post, head of therapy to have oversight of the whole therapy function and a facilities manager to bring together estates, catering and housekeeping. Support worker managers were put into place to ensure that oversight of support worker performance was kept and that staff were supervised, they were also there to help recruit. The senior support worker post had been created to allow nursing staff more time for direct care activities.

Leadership, morale and staff engagement

- The hospital had low sickness rates at 3% for the previous 12 months.
- Staff were aware of the whistleblowing process. There was an internal whistleblowing line for the Huntercombe Group which meant that if staff did not feel confident approaching their manager then they were able to anonymously use that line.
- Staff stated that they felt supported by their immediate line manager and by the hospital as a whole. Many said that where previously the hospital had problems things were getting better and that morale was improving. They felt that there was good team work and although there were claims that at ward level there was a hierarchy, on the whole staff felt that they were treated as equal. There was a hospital drive to promote and strengthen the role of the support worker and add greater value to the role.
- For staff working at the hospital there was an opportunity to engage in leadership courses, there was a budget for continuous professional development.
- Senior management had started a monthly newsletter called Four Rivers News which was a newsletter for staff informing them of updates in the hospital, new roles available to staff, new starters and leavers.
- The staff survey had showed an increase in ten points for their organisational health score. With the survey showing that 84% of staff felt that Huntercombe's top priority was care of patients and 93% feeling that their role makes a difference to patients.
- Management had begun communicating change through organisational health posters. A communication forum had been set up to see how they could improve staff communications across the hospital.

Commitment to quality improvement and innovation

Good

Child and adolescent mental health wards

- The hospital was a pilot site for looking at their care model to see how they can get the most out of staff engagement with the patients with less “specialling” (specialling is a term used for when a patient has a staff member observing them continuously on a one-to-one basis) and less agency usage.
- The Huntercombe Group had set up a clinical cabinet for heads of hospitals and leads to attend in order to discuss treatment and to ensure that they were providing a good service.
- Kennet ward had participated in the Quality Network for Inpatient CAMHS and was being assessed at the time of the inspection.

Outstanding practice and areas for improvement

Outstanding practice

- Patients at the hospital had triggered large changes and improvements by taking part in the Glamour Your Manor scheme. This scheme provided the winning hospital with a budget to carry out their improvement plans. In 2015 the user involvement group had requested an all-weather sports pitch usable for football, basketball and other activities, planting for the gardens, equipment such as goal posts, picnic benches, tables and gazebos and a sensory room. Patients led the proposal. The hospital won the money and carried out the improvements. Patients and families were asked what improvements could be made in the hospital in 2016. Plans for the Glamour Your Manor 2016 included securing funds to update the OT kitchen so that patients with an eating disorder could cook and eat with their families, improve parking facilities and getting better air conditioning in the PICU's.
- The hospital put on an annual fete in the grounds and invited ex-patients of the hospital back to attend. They felt it was an incentive for patients to come back and let the staff at the hospital know how they were doing and staff could hear about the care they provided in a more reflective way. Patients could also meet former patients and see recovery in action. The hospital provided a bouncy castle and put on a barbecue.
- There was a bi-monthly family and carers day provided so that families and carers could meet staff providing medical, nursing and therapy within the hospital, meet other parents and to ask questions about the care and treatment available.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all staff understand the Mental Capacity Act and Gillick competence. This is when a patient under the legal age of consent is considered to be competent enough to consent to their own treatment rather than have their parents consent.
- The provider must ensure that Gillick competence is assessed for each patient under 16 years of age and ensure that capacity is assessed for those over the age of 16. The Mental Capacity Act (MCA) 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 provider must ensure that all patients have their physical health monitored following rapid tranquilisation.

Action the provider SHOULD take to improve

- The provider should consider the appropriateness of the facilities used for seclusion. The en-suite room on Thames ward had been used as a seclusion room and this failed to comply with the hospitals policy on seclusion and the guidelines set out in the Mental Health Act Code of Practice. The use of this room for seclusion should be reviewed and changes should be implemented following the review.
- The provider should review blanket restriction on all of the wards to ensure they are clinically justified.
- The provider should ensure that all incidents are reported appropriately.
- The provider should ensure that care plans are less instructional to staff and reflect the patients view

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Regulation 11 HSCA (RA) Regulations 2014 Need for consent.** **All patients under the age of 16 were treated under parental consent rather than the individual consent of the young person. Staff had varying degrees of knowledge of the MCA and in particular there was very poor understanding of Gillick Competency** **This is a breach of regulation 11 (1) & (2)**

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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