Good

Somerset Partnership NHS Foundation Trust

Child and adolescent mental health wards

Quality Report

Musgrove Park Hospital,
Taunton,
TA1 5DA
Tel: (01278) 432000

Date of inspection visit: 8 - 11 September 2016
Date of publication: 17/12/2015

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RH5Y5	Wessex House	CAMHS Ward	TA6 5LX

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

Summary of findings

Ratings

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

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

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

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

- The ward was clean, tidy had anti ligature fittings and the bedrooms were en-suite. Emergency equipment and drugs were available, stored and monitored correctly. Staff adhered to infection control principles
- the ward was staffed consistently and levels were adjusted according to risk. Risk assessments were completed and updated regularly. There were low levels of restraint, patients physical and mental health needs were assessed. Therapies were implemented and there were outcomes recorded for patients
- staff received mandatory training, were supervised and appraised. Audits were completed regularly
- we heard positive comments about the care patients received from staff. Staff were professional, orientated patients to the ward, involved them in decisions and in their care planning. Families were involved in the care, carer assessments were offered. Staff sought feedback and implemented changes where possible. The ward was able to respond to changes in need
- there was a full range of facilities available and patients had somewhere safe to store their possessions. Activities and education sessions were available. Patients were aware of how to make a complaint
- systems were in place to monitor safety and efficacy of how the staff worked. Morale was good amongst staff and the manager was visible whilst having the autonomy to run the ward.

However:

- Parental consent or consent for those patients considered to be gillick competent was not recorded for any of the patients on the ward. (Gillick competence 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 admission assessments were incomplete. We found that the expected area of the notes that held admission information was not populated. This meant that staff were not able to easily access important information
- we found that some section 17 leave forms did not clearly set out the conditions of leave. Old section 17 leave forms were not always scored through.

Summary of findings

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

Are services safe?

Good

We rated safe as **good** because:

- The ward was fitted with anti ligature fittings, staff were able to observe patients around the ward to ensure their safety. Bedrooms provided were en-suite and well decorated. There was emergency drugs and equipment available. Call points were fitted throughout the ward to be used by staff and patients
- there was always a registered nurse on duty. The ward was staffed to allow for leave and activities. Staffing levels were increased according to risk
- risk assessments were completed for each patient and updated regularly, this ensured that staff were aware of current risks. Patients were observed according to their risk, observation levels were adjusted accordingly. Safeguarding training was provided. Staff reported incidents appropriately.

However:

- The admission assessments were incomplete. We found that the expected area of the notes that held admission information was not populated. This meant that staff were not able to easily access important information.

Are services effective?

Requires improvement

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

- Parental consent or consent for those patients considered to be gillick competent was not recorded for any of the patients on the ward. (Gillick competence 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 extra care area which had been used for de-escalation for patients that required more intense support was not being considered as seclusion or long term segregation despite it meeting the definition under the Mental Health Act Code Of Practice
- staff had not undertaken training in the Mental Health Act or Mental Capacity Act.

Summary of findings

- we found that some section 17 leave forms did not clearly set out the conditions of leave. Old section 17 leave forms were not always scored through.

However:

- Patients physical and mental health needs were assessed on admission. A physical health examination was conducted by the doctor for each patient on the ward
- medication and talking therapies were provided in accordance with NICE guidance. Staff had received specialist training based on NICE and Maudsley Hospital guidance. Outcomes were assessed using recognised models
- the multidisciplinary team was made up with a range of disciplines from a medical, therapeutic and nursing background. Patients were reviewed by the team at regular intervals.

Are services caring?

Good

We rated caring as **good** because:

- Patients had positive interactions with staff. Care we observed was supportive. Patients gave positive feedback that staff were polite and they respected privacy. Staff were professional and caring
- staff gave patients a tour of the ward on admission. Patients were involved in the planning of care and care plans created were personalised and holistic. Families and carers were included in the young persons review weekly
- there was a daily community meeting to communicate the activities and school timetable each day. Patients were able to feedback on the service using the participation group and the comment cards.

Are services responsive to people's needs?

Good

We rated responsive as **good** because:

- There was good bed management, the service responded to changes in need by moving patients according to risk. Admissions and discharges were conducted in the daytime. There were no delayed discharges in the preceeding six months leading up to the inspection

Summary of findings

- there were therapy and activity rooms. Patients were allowed their own basic mobile phone. There was supervised access to a fenced off garden. Activities were provided throughout the week where possible
- patients were able to personalise their bedrooms. They had a safe area to store risk items and personal possessions
- information about rights and how to complain was clearly displayed around the ward. There was access to spiritual support and an interpreter.

However:

- The assisted bathroom had no adaptations such as disabled fittings.
- The activity timetable was not consistently implemented. There was a reliance on nursing staff to provide activities.

Are services well-led?

Good

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

- Staff were aware of the trusts vision and values. Staff were trained and supervised
- staff audited to ensure they were working effectively and following procedures. Staffing levels were adjusted according to risk, the ward manager had the autonomy to run the ward. Team meetings were conducted monthly
- morale was reported to be good, there were low levels of sickness and absence. The ward was well-led at a local level.

Summary of findings

Information about the service

Wessex House is a 12 bedded inpatient service in Bridgwater Somerset for young people between the ages of 13-18 years who have a variety of mental health difficulties including depression, anxiety problems, eating difficulties, psychosis and post-traumatic stress disorder. Wessex House is set within its own grounds, surrounded by gardens. It is the only inpatient child and adolescent service within the trust. At the time of inspection only 10 beds in the hospital were open due to the trust not being able to provide adequate staff numbers for the full complement.

Our inspection team

Our inspection team was led by:

Chair: Kevan Taylor, Chief Executive Sheffield Health and Social Care NHS Foundation Trust

Team Leader: Karen Bennett-Wilson, Head of Inspection for Mental Health, Learning Disabilities and Substance Misuse, Care Quality Commission

The team that isnepcted this core services comprised: a CQC inspector, a CQC inspection manager, a mental health act reviewer and two specialist advisors with experience in child and adolescent mental health services.

Why we carried out this inspection

We inspected this core service as part of our ongoing 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?

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients at focus groups.

During the inspection visit, the inspection team:

- visited Wessex House and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke verbally with six patients who were using the service as well as collecting written comments
- spoke with the manager for the ward
- spoke with seven staff members; including doctors, nurses and therapy staff
- spoke with two family members of patients using the service

We also:

- reviewed all medication records
- Looked at seven treatment records of patients.
- carried out a specific check of the medication management

looked at a range of policies, procedures and other documents relating to the running of the service

Summary of findings

What people who use the provider's services say

A number of the patients on the ward wrote comments to us about the care they received. We were told that staff were polite and respected privacy, they offered treatment choices, knocked before going in bedrooms and that they were caring and interested in their well-being. However there were comments that they can sometimes not listen and that they were inexperienced in dealing with flashbacks and distress.

We spoke with parents of young people that were admitted to Wessex and were told it was a caring environment and that the standard of care was fantastic. One parent felt fully involved in the care and in treatment decisions and was fully included in the discharge planning arrangments.

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

- Staff must ensure that consent for care and treatment of all patients admitted to the ward is sought from the relevant person and clearly recorded in their care records. Staff must ensure that information is stored in the part of the notes that is specified. Essential information was missing from the admission section of the notes and was therefore not easily accessible.

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

Ensure that Mental Capacity Act and Mental Health Act training is undertaken by all staff. Whilst knowledge on the ward was good in the nursing staff we interviewed there was no guarantee that this correlated across disciplines and skill mixes or that staff would remain up to date with relevant changes to legislation.

Somerset Partnership NHS Foundation Trust

Child and adolescent mental health wards

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location

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 had received training in the mental health act, however, training records reviewed did not show any record of Mental Health Act training being offered.
- Detention paperwork was completed in line with the Code of Practice and was up to date. This was stored and available to the staff when needed.
- The ward stated that they did not use seclusion in their practice. The extra-care area was previously used as a seclusion room but this was decommissioned prior to the ward reopening in 2014. However, when patients risks increased such as an increase in violence and they required more intensive care that was separate from other young people, the area was being used for de-escalation. The Mental Health Act 1983 Code Of Practice states that 'if an individual under long-term enhanced observation is also being prevented from having contact with anyone outside the area in which they are confined, then this will amount to either seclusion or long-term segregation'. As a result the ward was not following the procedure for seclusion as set out in the Code of Practice and appropriate records were not kept when this area was in use. The unit had a new policy in place that would make them compliant in future and we saw that training had been booked for the staff team in the new policy.
- We found that some section 17 leave forms did not clearly set out the conditions of leave. Old section 17 leave forms were not routinely marked as void, leaving scope for error. This was particularly the case for one patient who had two concurrent leave forms. There was no indication if the patient had received a copy. There was no space on the form to clearly and unambiguously record if leave was unescorted, escorted or accompanied.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

- Training records showed that there was no mandatory Mental Capacity Act (MCA) training. There was no record of staff having completed the voluntary MCA training offered by the trust.
- All records of the patients were reviewed on the inspection. We found that on admission consent was not sought from patients or from parents. The admission pack prompted for consent to be gained but this was not completed in the necessary area of the electronic records. We reviewed the paper folders of the patients and found no record of consent for any of the patients. There was therefore no reference to gillick competency for any of the patients. Gillick competency relates to children and young people who are under legal the age of consent but deemed capable of consenting for themselves - multidisciplinary teams should discussed risks and agree an action plan to maintain confidentiality and not discuss treatment with the young person`s parents, unless it was not safe for them to do so. For example, if a young person was at risk of harm.
- We found that there was no recorded capacity assessments for any of the patients on the ward and no mention of the capacity of the patients on admission assessments.
- We spoke with staff about the Mental Capacity Act and it was clear they had understanding of the statutory principles of assessing capacity.

Good

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

- Wessex House was a purpose built unit for inpatient mental health care. All bedrooms were situated on one floor and visible from the nurses station. Lines of sight around the hospital were clear with viewing windows into rooms so that staff could observe from other areas of the ward. There were separate lounges and activity rooms that could be observed from the corridor if needed.
- The bedrooms had vistamatic windows so that patients' privacy and dignity could be respected. We saw that due to concerns about lines of sight into the rooms from the corridor, a number of the bedrooms had been placed on the local risk register in order for mirrors to be fitted to increase observation of the rooms.
- The en-suite bathrooms were fitted with anti-ligature curtains rather than a lockable door. From the nursing office staff were able to stop the flow of water into the room for patients that were at risk of water loading, which can be a way for patients to appear heavier when weighed, for example if they are deliberately restricting their intake of food.
- Bedrooms and bathrooms had anti-ligature fittings. Where it was not possible to have anti-ligature fittings, assessments were completed that identified ligature points throughout the hospital. However, this assessment did not provide staff with any action plan to mitigate the risk of these ligature points to patients. Therefore staff were not informed of how they might ensure the safety of patients on the ward. Ligature cutters were available.
- The ward was compliant with Department Of Health guidance on same-sex accommodation. All bedrooms were en-suite and there was a female only lounge. We heard from staff that they would try to ensure gender separation in the bedroom corridors where possible but due to risk this was sometimes not possible. They preferred to keep higher risk patients closer to the nursing office where they could be more easily observed.
- The clinic room appeared organised, clean and tidy. Emergency drugs were available and checked regularly, oxygen cyclinders were full and there was emergency equipment such as an Automated External Defibrillator. Records of checks of this equipment were kept and up dated. There was equipment to take physical observations, an examination couch, scales and a fridge to store medication. Temperatures were recorded and up to date.
- The ward had a separate extra-care area that was used for de-escalation of patients in distress or in the event of physical aggression. This area had a bedroom, de-escalation room with soft furnishings and a quiet area used for activity and to eat meals. The de-escalation room had a high ceiling with green walls and floor, this made it very dark and feel enclosed. Ward staff stated that they did not like to use the room because it was not a nice environment and was not conducive to calm patients. They often used the bedroom to de-escalate patients which was not equipped with the soft chairs which aid safe restraint of patients. There was a secure garden but this was accessible only from the main ward area. The de-escalation area had been used very infrequently.
- The ward appeared bright and was cleaned daily. Furnishings were in good condition throughout the ward. There were separate areas for activities and these appeared to be well equipped, clean and tidy.
- Staff adhered to infection control principles, hand washing audits were completed monthly. Clinical waste bags and sharps bins were available in clinical areas. A sluice room was situated in the bedroom corridor. Fire extinguishers were situated in the sluice room, however, there were no signs on the door to inform staff that they were stored inside. This was brought to the attention of the manager during the inspection.
- Patient alarms were situated on the walls in bedrooms and at various points around the ward. The pinpoint system allowed staff to carry an alarm that they could use to call staff if there was need for assistance. This alerted staff to the whereabouts of the staff member via

Good

Are services safe?

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a display on the wall in the nursing office and staff room. Staff were required to respond to these alarms across the hospital site which included adult mental health wards.

Safe staffing

- Wessex House used a three shift system with two day shifts and one night shift. They worked their staffing out on the ratio of one staff member for two patients in the day with extra staff on nine till five shifts and a twilight member of staff for the evening. This level of staffing meant that there were staff visible on the ward throughout the day. They were able to interact with the patients and there was a presence which meant that patients were observed. Staff numbers meant that escorted leave could be facilitated and activities provided.
- There was always at least two qualified nurses on a shift so patients were able to get 1:1 time regularly. The manager reported that 1:1 time should happen a minimum of twice weekly. The care plan review did not however audit the frequency of 1:1 time so this could not be verified at the time of the inspection.
- The ward had increased capacity to 10 beds two months prior to the inspection. There were still a number of staff vacancies to be filled until they could increase to their full complement of 12 beds. Prior to the increase to 10 beds the ward had used only four bank or agency staff to make up the numbers. From the point that the bed numbers were increased to 10 they were required to cover 21 shifts using bank or agency in each of the two months prior to inspection.
- The ability of Wessex House to recruit extra members of staff to ensure they can open the full 12 beds had been placed on the risk register. Staff felt that a national shortage of nurses was contributing to this. An action plan to start a recruitment campaign had been put in place to help resolve this.
- The manager advised us that she was given the authority to increase the staff levels according to patient risk. However, there was an expectation that if there was an adjustment to 1:1 observation levels that this would be absorbed in the numbers. Any extra 1:1 observations would trigger an increase in staff members.
- The staff numbers meant that there were a sufficient amount of staff to initiate a physical intervention while still allowing staffing presence in ward areas for the other patients.
- Medical cover was provided by a consultant psychiatrist and staff grade doctor in day time hours. Out of hours there was an on call consultant. However, the service had struggled to recruit a full time consultant. Psychiatric cover had been provided on a locum basis for some time.

Assessing and managing risk to patients and staff

- Risk assessments were completed using the template on RIO the electronic care records. The risk assessments were reviewed in the young persons review (YPR) each week and were completed on commencement and return of leave. Staff informed us that they continually risk assessed the patients throughout the day and that there was discussion of risk in handover. An audit of the handover confirmed that risk was discussed and was accurate to the recorded risk assessments.
- However we found that the admission assessments and recording of the risks on the assessment were not consistent as there were areas that were incomplete in the admission assessment area of the electronic notes. This made it difficult to find accurate up to date admission information about the risks and needs of the patients. The effect of this was that information about the patient was not readily available to those that needed it.
- We found that many of the areas throughout the hospital were locked off to the patients, for example, garden area, activity room, games room. Patients had to request to go into these areas. There was discussion ongoing amongst the team about how they could reduce this blanket restriction of locked areas whilst mitigating risk to patients. We found no other blanket restrictions on the ward.
- The ward had a locked door policy. There were two locked doors between the ward areas and the front of the building. Due to the mix of formal and informal patients there was a patients' rights poster on the doors stating that informal patients were free to leave at will.
- Patients admitted to the ward were risk assessed and placed on observations appropriate to their needs.

Good

Are services safe?

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

There was a policy of placing every patient on level two observations which was five times per hour without exceeding a 15 minute interval. This was reviewed after 24 hours.

- There had been recent incidents of patients bringing contraband items such as razors back onto the ward. As a result of this they had purchased a metal detector so that patients could be scanned for risk items on admission and on return of leave to ensure the safety of the ward.
- Patients were not allowed to smoke on the ward. Nicotine replacement therapy was available for those whose risk meant that they could not leave the ward for a cigarette. Patients were individually assessed around their smoking and a decision made about allowing them out based on this.
- There had been 13 incidents of restraint involving six different patients in the six months prior to the inspection. Three of these restraints were in the prone position. There was no use of rapid tranquilisation in these restraints.
- Safeguarding children level one training was above the 90% set by the trust. Levels two and three were below the 90%. However, staff were knowledgeable on the trust`s safeguarding policy, how to recognise abuse and how to report to the local authority. We saw evidence that safeguarding alerts were raised appropriately.
- Medicines for the ward were provided by an external contractor. These were available to be ordered daily with delivery six days per week. Medicines were stored securely, a controlled drug cupboard and book was available but had not been used for some time. An audit of controlled drugs was completed regularly. Medication charts were filled in appropriately. The pharmacist visited the ward weekly.
- There was an initiative to teach nursing mentors in medication management, this was so that they could show best practice and safe and knowledgeable administration of medicines to other staff members.
- Visitors, including children, were not allowed onto the ward area. There were rooms available to them in the corridor by reception.

Track record on safety

- There had been two serious incidents since the ward re-opened in 2014.
- One of the serious incidents related to an incident that had occurred while a patient was on leave. This had led to work to improve the detail of the risk assessments completed before people go on leave, consideration of the mix of patients that went on leave and sending a registered nurse out with groups. The manager had met with staff to go through the findings and action plans.
- An adverse event had occurred whilst the extra-care area was out of action, this had resulted in a transfer of a patient to an adult place of safety within the trust. Recommendations about the use of the extra-care area were made following this including a review and up-date of the policy.

Reporting incidents and learning from when things go wrong

- Incident reporting was completed electronically on a program called Datix. Staff were able to identify incidents that would need to be reported.
- Staff were not clear on where information went after being reported. They told us that there was little feedback about lower level incidents on the ward. We did however see that there was a ward based incident discussed in a staff meeting. There was an absence of learning from incidents from other areas of the trust.

Are services effective?

Requires improvement

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

- The needs of patients admitted to the ward were assessed on admission. This included mental and physical health and educational needs. The assessments completed informed the care plans which were created by the nurses in conjunction with the patient. The care plans were up to date and person centred including the patients point of view and likes and dislikes.
- A Commissioning for Quality and Innovation (CQUIN) target had been set to produce a patient portfolio so that patients had access to information about their care. This was yet to be implemented in practice but was a work in progress.
- On admission to the ward each patient had an admission pack which held information about the patient such as address and date of birth, physical health information and liability for loss of property. This was not filled in comprehensively for the patients we reviewed and areas of the admission process such as consent and capacity had been missed.
- Somerset partnership staff were able to access electronic notes about a patient if there was a transfer within the trust, we were informed that where a patient was transferred outside of the trust, they would be sent with paper notes relevant to their care.
- Physical examination was conducted on admission by the admitting doctor. A staff grade doctor was on the ward within normal working hours to monitor physical health of patients. Nursing staff were allocated to undertake physical observations of patients and would ensure that patients with an eating disorder were supervised sufficiently at meal times.

Best practice in treatment and care

- Although many of the medications used on the ward were not licensed for use in CAMHS, medication was prescribed according to NICE guidelines and in conjunction with talking therapies. For example one young person was prescribed fluoxetine as indicated in the NICE guideline for depression in children and young people. We found that medication was not the main focus of care at Wessex House. The medication charts showed that minimal amounts of medication were used.
- Dialectical behaviour therapy training was provided for staff, however, recent resignations had reduced the number of trained staff. Cognitive behavioural therapy and individual psychological therapies were available. The psychologist assessed all patients admitted to the ward. Family therapy was available and provided on the site but staff felt the provision of this needed to be increased due to demand.
- The policy for the treatment of eating disorders reflected NICE guidance, there had been advice and training gained around this from Maudsley Hospital.
- Within the care records we found regular use of Health of the Nation Outcome Scales Child and Adolescent Mental Health (HONOSCA) and the Children's Global Assessment Scale (CGAS) on the admission and discharge of young people. This ensured staff recorded severity and outcomes for patients in their care whilst providing a scale to show improvement.
- Audits were completed on suicide prevention which looked at patients notes to track management of risk, observation levels, family and carer involvement and discharge planning whilst measuring performance across these areas. Care plan reviews were completed, in addition to hand hygiene and handover audits.

Skilled staff to deliver care

- The ward provided a mixture of nursing and therapeutic care provided by a range of disciplines including qualified and unqualified nurses, psychologist, an occupational therapist, family therapist and a consultant psychiatrist. Despite the service providing treatment for patients suffering from eating disorders there was no dietician so they were required to refer to Musgrove Park Hospital. As a result dietetic input was not always available timely on admission.
- Mandatory training was provided by the trust but was at a completion rate of 85%. There was no training provided in the Mental Capacity Act or the Mental Health Act.

Are services effective?

Requires improvement

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- Staff received supervision monthly and were appraised yearly in line with trust policy. There was a reflective practice group available to staff every two weeks**.**

Multi-disciplinary and inter-agency team work

- The Young Persons Review (YPR) was a meeting with the patient and the multi-disciplinary team involved in their care. Patients were given review sheets to write feedback on treatment over the past week, what has changed and any treatment requests. This meant that the patients were able to give feedback to the team without them being there if that was their choice. There was a form for parents and carers to provide feedback to them team in a similar manner.
- The YPR provided the team an opportunity to discuss and review the progress and treatment of the patient. Risks were assessed and treatment changes made when needed.
- Handovers occurred from shift to shift for all nursing staff. A handover with the therapy team occurred each morning. A quarterly audit of handovers had taken place to monitor the process and standards of ongoing risk assessment.
- Staff told us that communication with teams outside of the hospital was varied but there was always involvement from community teams in discharge planning.
- Care Programme Approach (CPA) meetings occurred within the first two weeks of admission and then regularly thereafter. A discharge CPA was conducted to arrange on-going treatment in the community.

Adherence to the MHA and the MHA Code of Practice

- Staff had received training in the Mental Health Act, however, training records reviewed did not show any record of Mental Health Act training being offered.
- Detention paperwork was completed in line with the Code of Practice and was up to date. This was stored and available to the staff when needed.
- The ward stated that they did not use seclusion in their practice. The extra-care area was previously used as a seclusion room but this was decommissioned prior to the ward reopening in 2014. However when patients risks increased such as an increase in violence and they required more intensive care that was separate from other young people, the area was being used for de-escalation. The Mental Health Act 1983 Code Of Practice states that 'if an individual under long-term enhanced observation is also being prevented from having contact with anyone outside the area in which they are confined, then this will amount to either seclusion or long-term segregation'. As a result the ward was not following the procedure for seclusion as set out in the Code of Practice and appropriate records were not kept when this area was in use. The unit had a new policy in place that would make them compliant in future and we saw that training had been booked for the staff team in the new policy.
- We found that some section 17 leave forms did not clearly set out the conditions of leave. Old section 17 leave forms were not routinely marked as void, leaving scope for error. This was particularly the case for one patient who had two concurrent leave forms. There was no indication if the patient had received a copy. There was no space on the form to clearly and unambiguously record if leave was unescorted, escorted or accompanied.

Good practice in applying the MCA

- Training records showed that there was no mandatory Mental Capacity Act (MCA) training available to staff. There was no record of staff having completed the voluntary MCA training offered by the trust.
- All records of the patients were reviewed on the inspection. We found that on admission consent was not sought from patients or from parents. The admission pack prompted for consent to be gained but this was not completed in the necessary area of the electronic records. We reviewed the paper folders of the patients and found no record of consent for any of the patients. There was therefore no reference to gillick competency for any of the patients. Gillick competency relates to children and young people who are under legal the age of consent but deemed capable of consenting for themselves - multidisciplinary teams should discussed risks and agree an action plan to maintain confidentiality and not discuss treatment with the young person`s parents, unless it was not safe for them to do so. For example, if a young person was at risk of harm.

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Requires improvement

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.

- We found that there was no recorded capacity assessments for any of the patients on the ward and no mention of the capacity of the patients on admission assessments.
- We spoke with staff about the Mental Capacity Act and it was clear they had understanding of the statutory principles of assessing capacity.

Good

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

- The young people on the unit did not want us to observe an anxiety management group that was being run during our visit. However, we saw staff encouraging a high attendance in a firm but positive manner.This consisted of lots of polite respectful prompts pitched at different individual levels to ensure a positive response.
- We observed a young person who was sitting alone with some anxiety displayed.A member of staff sat near them and started an activity.The staff member respected their distance, but made frequent incremental attempts to engage by asking the young person's views on the activity.This received a gradual positive response from the young person who engaged a little more each time.
- A number of the patients on the ward wrote comments to us about the care they received. We were told that staff were polite and respected privacy, they offered treatment choices, knocked before going in bedrooms and that they were caring and interested in their well-being. However, there were comments that they can sometimes not listen and that they were inexperienced in dealing with flashbacks and distress. Due to the patients not wanting to talk to inspection staff we were not able to question further on this.
- Staff we met were all professional, caring and committed to providing the best service and care they could within their current resources.

The involvement of people in the care they receive

- On admission patients were given a tour of the ward and given their own bedroom. They had devised a leaflet that informed them of the function of Wessex House, what activities and therapies were available and informed them of contraband items. Staff had an admission sheet that prompted them to cover areas such as physical health checks and ensuring they had the right personal information.
- We found that patients were involved in the planning of their care and in making decisions. We found that care plans were given to patients and it was indicated when these were signed. The care plans were reviewed regularly by the team and contained up to date information.
- Care plans contained personalised information with patients' views and were holistic in their nature looking at a wide range of problems and needs whilst oriented around strengths and goals. There was reference to physical health where necessary and there was evidence of ongoing physical health monitoring.
- Staff were unclear on the current advocacy arrangements. We found that there had been a recent change in provider and as a result there was no longer a routine visit.
- Families and carers were provided with the opportunity to feedback during the Young Persons Review weekly. Parents were offered choice on time slots on when to receive updates on patients care. We found written evidence of feedback and input from families and carers. There was clear decision making around treatment and discharge arrangements involving the patient and families.
- Carers assessments were offered to families and carers when needed. Family liaison meetings were conducted early on in the admission to seek parents and patients views.
- Community meetings were conducted daily to communicate the timetable for the day including therapy, school and activities. This was also an opportunity for patients to talk to staff about any issues that had arisen over the previous 24 hours.
- There was a young people's participation group with both current and former patients a part of this group. This group was a platform for patient feedback. A feedback box was available for patients and carers in the reception area. We were also informed that patients were invited to complete a feedback form on discharge.
- A 'you said we did' board was on display in the patients corridor so that staff could show patients how they were responding to issues on the ward.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

- There was good management of beds as patients that were on leave were able to return to the hospital at any point and were able to access the same bedroom. There was not a policy to admit into leave beds.
- The service was able to respond quickly to changes in need. Whilst there were no psychiatric intensive care (PICU) arrangements within the trust there was the ability for staff to use the extra care area. The policy for use of the extra care area was that patients would be moved on if they were not able to return to the main ward area within three days. They were also able to facilitate the use of the local S136 places of safety at Rowan and Rydon wards. When the S136 places of safety were used this was flagged up as an admission to an adult mental health ward and considered a serious incident. These places were only used as a last resort and would be the trigger to finding alternative placement of the patient.
- Staff told us that discharges from the ward generally took place during the daytime, with no weekend or night-time discharges. They said that the process for discharge would be through the young person taking increasing periods of leave away from the ward, and their progress assessed during the ward rounds.
- Information provided by the trust reflected that Wessex House had not had any delayed discharges in the previous six months.

The facilties promote recovery, comfort, dignity and confidentiality

- Facilities on the ward included a fully equipped patients kitchen, games room, lounge with TV, activities room, therapy rooms, dining room and female only lounge. Board and computer games were available, there was a football and swing ball in the garden. Patients had access to the internet in the education area.
- Patients were able to meet their visitors in the main corridor prior to the main locked ward door. This was a quiet area and allowed patients some privacy.
- There were no public phones on the ward but patients were allowed to use the office phone for calls if needed. Mobile phones were allowed on the ward providing there was no inbuilt camera or internet access.
- The ward had two outside areas, one was a more secure garden for patients in extra-care to use. The main garden area was large with grass and a small shelter which was there to protect patients from rain. We heard that the gardens were open to patients but needed to be supervised by staff.
- Food was provided by an external contractor. Cold portions of food were delivered daily and heated up on site. Reports on the quality of the food were varied. Patients were allowed to access the kitchen under supervision in the evening so that they could prepare their own food.
- Snacks supplied by the ward were available throughout the day but there were specified snack times for patients to have their own food such as chocolate, sweets and crisps. This was done in order to promote good dietary choices and to be sensitive towards the mix of the patients. Drinks were available throughout the day and night.
- Patients reported that they were able to personalise their bedrooms. We saw from a tour of the bedroom area that patients had done this.
- Patients had their own rooms to store their possessions, they did not however have their own keys. Any risk items or personal possessions that needed storing safely were inventoried and placed in their own personal box which was locked away. Patients were able to access these through the staff.
- Activities were provided from occupational therapy and nursing staff. A timetable was drawn up which included more formal therapeutic sessions as well as the less formal art groups and games sessions. We heard from patients that this was not consistent in its delivery and often there was not a lot happening at the weekends. We found that whilst the timetable had been implemented there was a reliance on nursing staff to deliver the sessions and they were often getting missed despite staff being allocated.

Are services responsive to people's needs?

Good

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

- An education timetable was in place for weekdays. The service provided 15 hours of education per week. The teachers liaised with schools to ensure that work relevant to a patients development was available to them.

Meeting the needs of all people who use the service

- The ward had a larger allocated assisted bathroom for disabled people. However, there were no disabled fittings and the bath was very low. A hoist was available for those that needed it. There were no adapted disabled bedrooms throughout the hospital.
- Information about complaints, treatments, contacts and the trusts vision was clearly displayed throughout the ward. Information leaflets about Wessex House were available on admission. A poster on patients' rights for formal and informal patients was placed by the door of the hospital.
- There was access to an interpreter through the trust, information could be provided in different languages upon request.
- Access to spiritual support was clearly displayed in the hospital, whilst there was no routine visitor from faith representatives there was a clear ability for patients to be able to access this support.

Listening to and learning from concerns and complaints

- Young people knew how to raise concerns and make a complaint. They said they would raise this with staff initially, and take this further if they were not happy with the response. Most said that they felt able to raise a concern should they have one and believed that staff would listen to them. However, others did not feel they would be supported.
- Complaints information was clearly displayed on the walls in the hospital.
- We found that staff did not always receive feedback following complaints from service users. There was no local log kept of complaints so trends could not be identified and monitored. As a result there was no evidence of learning from complaints.

Are services well-led?

Good

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

Our findings

Vision and values

- The trusts values were clearly displayed in ward areas. Staff commented that they knew of the values but some felt that they were weak and lacked a robust direction.
- Whilst it was clear that staff on ward level knew of the senior managers and executive team at the trust they felt that the only time they heard from them was when something negative happened. The ward staff did not feel listened to and that they were a forgotten service.
- Staff advised there was fear of speaking up about the trust. There was little challenge to the corporate view which created a culture that was not open.

Good governance

- Staff on the ward received training and supervision as per the trust policy. Specialist training was provided in house.
- The service had systems in place to ensure safety of care through the suicide prevention audit, they monitored the efficacy of handovers and ensured staff followed infection control procedures through monthly hand hygiene audits. However, due to the service being part of a combined trust, they were required to undertake audits that were not relevant to them such as a faecal incontinence audit. Staff felt that this was not a productive use of their time.
- The ward manager had autonomy to adjust staffing levels, arrange meetings and trips out for the patients. Access to support through administrative staff in the hospital was available.
- There was a local risk register that had items on so that the risks could be identified, escalated and addressed. For eample, recruitment issues and how this impacted on the service.
- Monitoring of performance on sickness levels and training compliance was held at higher levels than the ward and fed back down, key performance indicators were therefore not monitored from a local level.
- Team meetings occurred monthly with nursing and therapeutic staff, there was little evidence of learning from complaints or incidents in the minutes.

Leadership, morale and staff engagement

- The team at Wessex House was newly established and had been together for under a year in their current team structure.
- Morale was good with low sickness and absence rates.
- Staff were aware of how to complain to their manager and were aware of the whistleblowing policy.
- We found the ward was well-led. There was evidence of clear leadership at a local level. The ward manager was visible on the ward during the day-to-day provision of care and treatment. The team appeared to work well together on the day of our inspection and there was a positive attitude displayed from all.
- There was access to leadership development for band 6 nurses and above.
- At the time of our inspection there were no grievance procedures being pursued within the wards, and there were no allegations of bullying or harassment.

Commitment to quality improvement and innovation

- There were no current commitments to quality improvement through national initiatives such as Quality Network for Inpatient CAMHS (QNIC). There were plans in the future to take part in QNIC.

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(1) HSCA 2008 (Regulated Activities) Regulations 2014** **There was no recorded consent for any of the patients on the ward. We found that admission check lists had missed out this area and that doctors were not routinely populating the required area of the notes with consent. We found no written parental consent for any of the patients on the ward or any reference to gillick competency for those under 16 and able to consent.** **This was a breach of Regulation 11(1).**