Watcombe Hall

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

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

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

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

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

Summary of findings

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Summary of this inspection

Background to Watcombe Hall

Watcombe Hall is an independent child and adolescent mental health (CAMHs) independent hospital provider, with a ten bedded specialist in-patient service that provided care and treatment for children and adolescents aged 13 - 18 years.

Watcombe Hall is commissioned by NHS England to provide specialist tier four services for the assessment and treatment of severe and complex mental health disorders for children and adolescent patients. The service was part of a specialist mental health services division (Huntercombe group) of Four Seasons health care.

Patients could be admitted informally with parental consent, if under 16 years, or detained under the Mental Health Act.

There were two specialist units comprising of a four bedded psychiatric intensive care unit (PICU) and a six bedded specialist adolescent unit.

There was a registered manager in place.

The unit was full, with ten female patients in residence at the time of our inspection.

Our inspection team

The team that inspected the service comprised of two CQC inspectors, a mental health act reviewer and a child and adolescent mental health service specialist nurse.

Why we carried out this inspection

We reviewed three areas in response to concerns raised around safety and effectiveness of the organisation. During our inspection we looked at whether services were safe, effective and well led. This was the first inspection of Watcombe Hall specialist child and adolescent in patient service. We did not rate the service on this inspection.

How we carried out this inspection

We reviewed three areas in response to concerns raised.

We looked at the following areas:

- Is it safe?
- Is it effective?
- Is it well-led?

This was an unannounced visit and we did not rate the service on this inspection.

Before the unannounced inspection, we reviewed information that we held about the location and asked other organisations for information about the service.

During the inspection visit, the inspection team:

- visited both units and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with two patients who were using the service
- spoke with the registered manager and service manager
- spoke with five other staff members; including doctors, nurses and health care assistants
- received feedback about the service from care coordinators or commissioners
- spoke with an independent advocate
- attended and observed a multi-disciplinary meeting

Summary of this inspection

- looked at four care and treatment records including risk assessments; and
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We observed a discussion of the care of three patients during a multi-disciplinary team meeting and spoke with two other patients. One patient expressed satisfaction and told us that the environment was relaxed and that staff were caring and supportive. Patients were supported to attend local community activities such as college. We spoke to two patients during our inspection, as the rest of the patients were attending school or were too unwell to speak to us. We observed that staff were attentive to patients and that despite high levels of observations the environment appeared relaxed.

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?

- The environment was clean and the layout allowed staff to observe all the communal areas.
- Blind spots were mitigated by mirrors, closed circuit television (CCTV) and observation levels.
- Safe staffing levels were in place using nationally recognised guidance and were adjusted when more staff were needed at particular times of the day or night.
- All staff were trained in de-escalation and restraint.
- Staff knew how to report incidents and there was regular feedback from these incidents to improve practice.

However,

- Incident records were not easily accessible.
- Risk assessments were not detailed and did not provide evidence of collaboration with multi disciplinary staff or patient involvement and family involvement.

Are services effective?

- Patients had access to a range of psychological therapies.
- Staff received training to undertake their specialist roles and were supported to complete mandatory and developmental training.
- There was regular support, appraisal and supervision for staff.
- There was effective working relationships with key staff, such as GPs and the local authority.

However:

- The service was moving from paper to electronic care records at the time of our inspection and we found the quality of some care records was variable. Information was not easy to locate and some records were incomplete.
- There was no recorded evidence of physical health care monitoring.
- One patient detained under section 5 had been given medication without their consent.
- Consent, particularly in relation to the MHA Code of Practice was not always clearly recorded.

Summary of this inspection

Are services well-led?

- There was a dedicated specialist manager. Staff knew the senior management team and felt supported.
- Morale was good and staff felt able to raise concerns if they needed to.
- There was good team working and mutual support and effective supervision and training systems.

However;

- Transition arrangements in moving from paper to electronic care records were not robust enough to ensure staff were aware of how to access some clinical and management information.

Child and adolescent mental health wards

Safe	
Effective	
Well-led	

Are child and adolescent mental health wards safe?

Safe and clean environment

- All areas we saw were clean. The décor was well maintained and furnishings were in good condition. We saw that staff adhered to infection control principles and hand washing guidance signs and hand gel were located throughout the building.
- There was a maintenance and housekeeping team who kept up to date records to demonstrate that the environment was clean and well maintained.
- The clinic room was clean and tidy. It contained appropriate equipment including a blood pressure monitor, scales, hand washing basin and examination couch.
- Equipment was clean and maintained. Portable appliance testing stickers were in date.
- Staff carried portable alarms and call buttons were located in each room.
- The layout of the communal areas allowed staff to observe all areas. There were blind spots around the unit but they were mitigated by mirrors, closed circuit television (CCTV) cameras, positioning of nursing staff and observation levels. In addition, all external and internal doors and corridors were locked. There was CCTV throughout the unit with the exception of bedrooms and bathrooms.
- There were anti ligature windows in all the patient areas including bedrooms, and anti-ligature shower curtains.
- Nurses were present in each communal area at all times. The layout of the psychiatric intensive care unit (PICU) allowed clear line of sight observation at all times. The general ward communal area also allowed patients to be observed.

Safe staffing

- Staffing levels were assessed using the Royal College of Psychiatry (RCPsych) quality network for inpatient child and adolescent unit staffing (QNIC) standards to ensure that the number of nursing staff on the unit were sufficient to safely meet the needs of the young people at all times. However, the manager explained that as the QNIC standard was based on a purpose built building the service had employed a specialist nurse to ensure that staffing levels were sufficient as the building was not purpose built. Staffing was also adapted at times when more staff were needed at different times of day to support the patient group.
- Staffing ratios had been agreed as a minimum of four staff in the six bedded ward and four staff in the four bedded PICU during the day. At night there were three staff in each unit. This included two qualified nurses on each unit during the day and one qualified nurse on each unit at night. There were also supernumerary qualified staff, such as the manager who worked Monday to Friday 9am to 5pm.
- The manager was able to adjust the staffing and the duty roster to accommodate the needs of the client group. For example, the unit was currently working with a twilight shift as more staff were needed to provide observation and support later in the day.
- The service was meeting their agreed staffing levels with four qualified staff on duty and four health care assistants. The supernumerary manager was working as one of the qualified staff on the day of our inspection, due to a last minute arrangement with a staff member. The staff roster confirmed this. We reviewed a recent sample of the duty roster and saw that agreed safe staffing levels were maintained. Overall there was low and appropriate use of bank and agency staff.
- Only agency and bank staff that were familiar with the unit and had undertaken training were used in the unit. This was confirmed by two staff. However, staff told us that they felt less safe with agency staff because they did not know the patients as well as the permanent staff.
- The manager reported that staffing turnover was low and only one member of staff had left the service since it started.

Child and adolescent mental health wards

Assessing and managing risk to patients and staff

- The ward did not have a seclusion room and did not use seclusion. The ward had a de-escalation room which was sometimes used to help patients calm down and to de-escalate situations. The manager described the room as a low stimulus space for use when patients needed this. The manager confirmed that the room was never locked when patients were in it and that patients were never left in the room without staff when used for de-escalation. We were also told that patients could also use the room as a quiet space.
- All staff had received accredited breakaway and restraint training and the service was 100% compliant with this training.
- We reviewed the records of four patients on the ward. Each patient had a completed risk assessment checklist and these were updated in the weekly multidisciplinary meeting that we observed. Risk assessments that were in place were brief and did not fully describe the risk, such as a risk of self harm. Staff confirmed that these were the main risk assessments.
- Patients were encouraged not to be in their rooms during the day Monday to Friday because the ward supported patients to attend the on-site school during normal school hours. However, there was not a blanket restriction and patients could get access to their rooms during the day.
- Staff were all trained in safeguarding children and there was 96% compliance with this training. The remaining staff were booked to receive this training.
- All staff we spoke with understood how to escalate safeguarding issues.

Track record on safety

- All staff we spoke with understood the incident reporting policy and knew what incidents needed to be reported and how to report them.
- We reviewed recent serious incidents. There were three incidents between July and September 2015. We saw that incidents were reported and were submitted for monitoring by their commissioners. There have been no never events reported. However, the manager had difficulty in locating some records and we were unable to review recent incidents of restraint.
- Staff confirmed that they received feedback on incidents and were confident that the service was transparent and issues were explained to patients if things went wrong. There was discussion around serious incidents at staff meetings and group supervision and staff told us that they felt supported when there had been incidents.
- There was a clear complaints process and patients and their parents were supported to complain or comment to their key worker, any staff or the patient advocate.

Are child and adolescent mental health wards effective?

(for example, treatment is effective)

Assessment of needs and planning of care

- Staff told us there was regular physical health monitoring for all patients at the local GP clinic. However, records were not kept to confirm this. We reviewed four care plans and risk assessments. We did not see evidence that a physical examination had been undertaken on admission or of on going physical health monitoring. The service was in the process of strengthening their physical health care arrangements and recording and had just recruited a registered general nurse to support physical health care needs. There were also plans to recruit a paediatric nurse.
- We reviewed four care records and found that the quality of these was variable. For example, one was easy to locate, personalised and up to date but two records lacked documentation or documents were filed in the wrong place. The service had conducted a recent care plan audit which found a lack of documentation, such as, regularly recording of physical health care checks and clinical risk assessments. Plans to improve this were in place through the transition to electronic records. The move had been planned with staff training in place. However, staff we spoke with were not yet confident and there were difficulties locating electronic documents that we requested. The manager explained that difficulties with record keeping had recently been exacerbated by the service moving from paper to electronic care records.

Child and adolescent mental health wards

Best practice in treatment and care

- Patients all had access to a range of individual and group psychology therapies, such as cognitive behaviour therapy. There was a dedicated consultant psychologist who provided psychological support to patients in both units.

Skilled staff to deliver care

- There was a full range of specialist mental health disciplines and workers, including a dedicated psychiatrist, psychologist, occupational therapist and a social worker. There were specialist nurses and trained health care assistants. The service had just recruited a registered general nurse to support physical health care needs and was in the process of recruiting a paediatric nurse.
- The service had retained 50 percent of its staff when they changed to an adolescent unit. All staff had received work experience in an established independent CAMHs unit prior to working at Watcombe Hall. Staff confirmed they had received regular statutory and mandatory training. We reviewed the training records and the quarterly report to the commissioners which outlined provider compliance with mandatory training.
- Staff received an annual appraisal and monthly supervision. The service was 85% compliant with formal monthly supervision. Staff we spoke with confirmed that they received regular supervision and support through their one to one supervision meetings and group support, such as team meetings.
- We reviewed training records and saw that staff received a range of specialist training, such as child and adolescent mental health training and control and restraint training. There were also development opportunities for staff, for example, two staff were currently undertaking master degrees in child and adolescent mental health.
- The manager also confirmed that all staff without specialist CAMHs training were required to shadow staff at the company's other specialist adolescent unit in Maidenhead as part of their induction.

Multi-disciplinary and inter-agency team work

- There were weekly multidisciplinary meetings and detailed handovers took place at each shift change. We observed a multidisciplinary meeting that took place on the day of our visit. The multidisciplinary team included a psychiatrist, consultant psychologist, nurse and occupational therapist. We saw that there was good patient involvement in their individual care including risks and discharge planning. Patients attended the multi-disciplinary meeting and an advocate was present to support patients.
- There was effective and collaborative working relationships with teams outside of the organisation, including with the local authority approved mental health professionals (AMHPs) and the local authority designated officer (LADO) and regular liaison with the GP where patients attended the local surgery for physical health monitoring.

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

- All staff we spoke with demonstrated a good understanding of the Mental Health Act (MHA) and had received training in the MHA in both team learning and individual e-learning. We reviewed the training records and saw that MHA training was included in the training matrix. Some staff were not up to date with the eLearning package as a result of a change in the eLearning application which had caused a delay. This was being reviewed and dates had been set for staff to complete the e-learning.
- We reviewed the use of MHA holding powers in response to concerns raised. We did not review the detention paper work for the other care records in detail as this was reviewed during a recent mental health act visit. We saw on one patient record that they had been detained on section 5(4) followed by 5(2) on two separate occasions in recent months. We noted that this was within agreed MHA Code of Practice timeframes. However, rapid tranquilisation had been given during this time, which was not in line with the MHA code of practice. We could not see records of an assessment of whether the patient was assessed as Gillick competent, or had consented to this treatment. These were accepted guidelines where services ensured parental consent where the young person may not have sufficient maturity to understand their treatment.
- We also did not see a record of parental consent, although we were told by staff that this had been given.

- One certificate of consent to treatment (T2) was not up to date, although staff took immediate action and attached the updated T2 certificate to the medicines chart during our visit.
- Patients detained under the MHA were informed of their rights and there was information for patients and families that provided additional information on patients' rights.
- The service had access to a named qualified independent mental health advocate (IMHA) and there were leaflets and information available for patients and families on how to contact them. The IMHA was well known to the ward and patients and staff all knew how to get access to support from the IMHA. The IMHA was present on the day of our inspection and was supporting patients to understand their rights during the multidisciplinary team meeting.
- We saw that patients were informed of their rights on admission or when they were first detained. Patients we spoke with confirmed this. However, in the records that we reviewed we did not see written evidence that patients were regularly re-informed of their rights and checks made to ensure that they understood their rights throughout their detention period.

Good practice in applying the Mental Capacity Act

- The Mental Capacity Act (MCA) only applied to young people aged 16 years and over. The deprivation of liberty safeguards applied only to people aged 18 and over.
- All staff at Watcombe Hall we spoke with had received training in the MCA this included face to face group team training as well as individual e-Learning. We saw that MCA training was included in the training matrix.
- Staff were able to demonstrate understanding of the statutory principles of assessing capacity and gave examples such as the rights for individuals to be supported with their decisions and least restrictive interventions.
- Patients were supported to make decisions where possible and appropriate and we saw that this took place in our observations of the multidisciplinary team meeting.
- The independent mental capacity advocate (IMCA) was available to support patients with their decisions.

Are child and adolescent mental health wards well-led?

Vision and values

- Staff we spoke with knew and understood the organisation's values at Watcombe Hall and the overall specialist provider. Staff were aware that the organisation focused on valuing the individual and caring for patients in a safe therapeutic environment. Staff understood young people's rights. We saw that information for patients and parents included an emphasis on rights, advocacy and confidentiality.
- There was a dedicated specialist manager on site and senior managers. Staff knew who the senior managers in the organisation were and confirmed that senior staff visited regularly.

Good governance

- The unit had a good leadership team in place. Staff were supervised and received the specialist training for their role. As a result, staff told us that they felt well supported.
- The provider submitted a range of key performance indicators and submitted monthly NHS England commissioner targets. The service had achieved their compliance targets for CAMHS tier four specialists in patient services.
- There were systems in place to monitor that the unit had met their compliance target and to ensure that staff received regular supervision and annual appraisals.
- Performance was addressed in supervision meetings and recent action had been taken to address areas of poor performance.
- Systems were in place to ensure that staff were trained in and understood safeguarding, incident reporting and the requirements of the MHA and MCA.
- However, the governance arrangements in moving from paper to electronic care records were not robust enough to ensure that clinical information was fully accessible and available.

Leadership, morale and staff engagement

- There was a specialist CAMHs manager in place supported by the registered manager and the service and quality assurance leads.

Child and adolescent mental health wards

- The staff we spoke with told us they enjoyed working at Watcombe Hall. They told us there was good teamwork on the unit and staff told us that felt motivated in their work with the patients.
- There was opportunity for leadership training and progression and two staff had been supported to attend Royal College of nursing (RCN) leadership courses.
- Staff knew how to whistle blow and were confident about how to raise concerns.
- Staff felt supported by the managers and job satisfaction and morale was good.
- The unit had introduced an incentive for all staff following staff feedback called the 'Huntercombe hero.' The manager had been given a budget to reward staff, such as extra annual leave for long service and thank you meals or social nights out.
- There was good team working and mutual support. However, two staff expressed concerns about staffing levels , particularly when patients needed extra support due to their mental state. The service had mitigated this by increasing staff in the evening when the manager and multidisciplinary team had noted that more staff were needed to support and observe patients.

Commitment to quality improvement and innovation

- The provider had nominated their service for the Laing Buisson independent specialist care awards and had been successfully shortlisted for this. The award ceremony celebrated quality, improvement and innovation within independent hospitals and specialist care in the UK.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that there is written evidence of ongoing physical health care monitoring undertaken by clinicians.
- The provider must ensure that care records are accurate and complete and include records of detailed risk assessments.
- The provider must ensure that consent is always obtained and clearly recorded in accordance with the MHA Code of Practice.
- The provider must ensure that the MHA Code of practice is followed in respect of medication given without consent for patients detained under section 5 of the MHA.

Action the provider SHOULD take to improve

- The provider should clearly record when detained patients are re-informed of their rights.
- The provider should ensure that all incident records are complete and easily accessible.
- The provider should ensure that all staff have access to e-learning records.
- The provider should ensure that all staff are trained to use electronic care records.

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 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services 17 (2) (c) Maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a complete record of their care and treatment and decisions taken in relation to their care and treatment:- Risk assessments, care plans and physical health care records were not complete and up to date and there were delays in filing information.

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) Health and Social Care Act 2008: Care and treatment of service users must only be provided with the consent of the relevant person:- Where a young person lacked mental capacity to make an informed decision or was not considered Gillick competent, it was not clear if consent was always obtained and recorded in accordance with the Mental Capacity Act 2005 and associated code of practice.