Care Quality Commission

The Whittington Hospital NHS Trust

Child and adolescent mental health wards

Quality Report

The Whittington Hospital, Magdala Avenue, London,
N19 5NF
Tel:02072723070
Website:http://www.whittington.nhs.uk/

Date of inspection visit: 8-11 December 2015
Date of publication: 08/07/2016

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RKE	The Whittington Hospital	CAMHS Wards	N19 5NF

This report describes our judgement of the quality of care provided within this core service by The Whittington Hospital NHS 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 The Whittington Hospital NHS Trust and these are brought together to inform our overall judgement of The Whittington Hospital NHS 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?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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

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

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

Summary of findings

Contents

Summary of this inspection	Page
Overall summary	4
The five questions we ask about the service and what we found	5
Information about the service	8
Areas for improvement	8
Detailed findings from this inspection	
Findings by our five questions	10
Action we have told the provider to take	21

Summary of findings

Overall summary

Information about the service

Simmons House was an in-patient adolescent psychiatric unit, for young people between 13 and 18 years of age. It consisted of a mixed gender 12 bed unit.

The unit could admit patients in an emergency or for a planned longer outcome-focussed admission of between six and nine months. The length of stay at Simmons House depended on the young person's needs and collaborative aims and goals.

Adolescents and their families or carers received an individually planned and structured treatment package combining as needed the following; Psychiatric assessment and medication, nursing input and care, family therapy, individual therapy and individual psychology, occupational therapy and group work and education.

The service was commissioned by NHS England and took patients from across the country. The admitted patients had a variety of mental health needs.

Before the inspection visit, we reviewed the information that we held about these services.

During the inspection visit, the inspection team: Visited the unit and looked at the quality of both the environment and observed how staff were caring for young people. Spoke with six young people who were patients at Simmons House. Spoke with one parent/ carer. Spoke with the two managers. Spoke with 12 members of staff including doctors, nurses, therapy staff and support workers. Attended and observed one handover meeting.

We also looked at 12 drug charts. Looked at seven care records for young people. Looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of findings

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

Are services safe?

We rated safety for CAMHS inpatient services as **requiring improvement** because;

Requires improvement

Patients' risk assessment and management plans were not always updated after an incident, which meant that staff might not be aware of new risks affecting the patient.

The oxygen cylinders were stored on the top of a tall cupboard; there was no footstool readily available to aid access to this life saving equipment.

The ligature risk assessment was not thorough; it had not identified all the ligature anchor points in the unit. Patients' bathrooms had a number of ligature anchor points. Many patients were unsupervised in these rooms. These risks were not sufficiently mitigated.

There was no clear label on the emergency resuscitation bag. This might cause delay in locating it.

Staff had completed daily checks on the emergency equipment to make sure it was fit for purpose. However, it was unclear what equipment had been checked. There was incorrect calibration of the equipment used to check the physical health of patients. There was a risk that the recordings would have been inaccurate and staff might not have responded promptly to a decline in the physical health of a patient.

However:

The environment was well maintained and clean. The service was well staffed and some members of the team had been at Simmons House for a number of years. The service was able to adjust staffing levels according to the needs of the patients and there was always medical cover.

There was clear learning from incidents and this was apparent across the unit. Staff had been trained in safeguarding and knew how to raise alerts. Staff were encouraged to develop their skills and the unit had development days to which they invited guest speakers. Appropriate procedures were followed during and after the restraint of a patient.

Are services effective?

We rated effective as **Good** for inpatient CAMHS because:

Good

Summary of findings

The service was young person focussed and recovery orientated. Staff completed comprehensive assessments of patients after admission. These assessments included patients' physical health and referrals were made to specialists when necessary.

Both the patient and their families were offered therapy sessions. NICE guidance was considered when prescribing medication. The service used specialist therapeutic interventions recommended by NICE. The unit used outcome measures to monitor the progress of patients.

There were regular meetings for staff, which gave them the opportunity to reflect on the work they undertook with patients. Staff members had regular supervision and appraisals.

The unit met the nutrition and hydration needs of patients fully.

The Royal College of Psychiatrists' Quality Network accredited Simmons House as "excellent".

Are services caring?

Good

We rated caring in CAMHS inpatient as **good** because;

Staff demonstrated compassion and caring for the patients and their families. The language to and about the patients was respectful. Patients felt safe at Simmons House. They were complimentary about the majority of the staff and felt staff cared about their well-being. Young people contributed to their care plans and were fully involved.

The parent we spoke with thought the staff group were supportive. They had considered her views during the care planning process.

Staff recognised the patients' cultural and religious needs.

Are services responsive to people's needs?

Good

We rated responsive as **good** for CAMHS inpatient because;

Patients were supported with their cultural needs and religious needs. The unit was able to admit patients who had impaired mobility.

Discharge plans started at the point of admission. When patients went home on leave, their in-patient bed was kept for them.

Patients were encouraged to air concerns and there was a clear complaints procedure. The staff considered patient feedback and the unit had made improvements as a result. There was support from a young person's advocacy service and they visited the unit regularly.

Summary of findings

There was good education provision at Simmons House. There was an expectation that all patients would participate. The range of activities at the unit was good.

Are services well-led?

We rated well-led as **good** for CAMHS because;

Good

The staff reflected the values of the trust. They were committed to the work they undertook with patients and their families. The governance structures were robust and there were clear processes to monitor the quality of the work undertaken by the team.

There was a culture of openness and transparency at Simmons House. The team were supportive of each other. Staff said they felt listened to and supported by their managers. There was clear leadership at a local level, however, some staff members stated that they felt a little distanced from the trust.

There was a commitment to continued improvement and Simmons House was accredited as “excellent” by the Royal College of Psychiatrists’ Quality Network for inpatient CAMHS.

Summary of findings

Information about the service

Overall we rated children and adolescent mental health inpatient services as **good** because;

Skilled and experienced staff treated young people accessing Simmons House with genuine kindness and respect. We observed positive, kind and caring interactions between staff and the patients. Staff knew patients and their individual, holistic care needs well. Patients were routinely involved in their care planning and community meetings. Families and carers were welcome on the unit and involved in care planning and decision making. Staff members reflected the values of the trust and were committed and passionate about the work they did with young people and families.

The Royal College of Psychiatrist' Quality Network (QNIC), accredited the service as "excellent" for Inpatient Child and Adolescent Mental Health Services (CAMHS). It was one of 11 services out of 111 to receive the excellent accreditation.

The number of staff on shift was adequate to meet the needs of patients. Patients could access a range of activities and escorted leave, which staff facilitated.

There was low use of restraint and we heard good practice from staff members regarding using de-escalation and preventing the need for restraint.

There was a strong multi-disciplinary team (MDT) and their meetings were well attended.

Staff showed a good understanding and met the requirements of the Mental Health Act, code of practice, guiding principles, consent to treatment and capacity requirements. Patients had their rights explained to them on admission. Patients had access to advocacy services.

There was a good range of group and individual activities, which included both therapeutic and social activities.

There was a comprehensive educational programme for patients.

The staff had robust systems for reporting incidents and there was clear evidence of staff learning from these. The safeguarding of patient's was a priority and all staff had received training in safeguarding young people. There was an awareness of the guidance on minimising the risk of child sexual exploitation.

Staff undertook weekly checks on emergency equipment but the checks lacked detail. Equipment used to check the physical health of patients was incorrectly calibrated. There was no assurance that the physical health checks for patients were accurate.

The update of patient risk information was not always completed. Four records did not have updated information about the risk posed by the patient. The risk management plan for these patients was not clear, which meant that staff might not be able to respond appropriately.

Areas for improvement

Action the provider MUST take to improve

The provider must ensure that oxygen cylinders are easily accessible in an emergency.

Action the provider SHOULD take to improve

The provider should ensure that patient risk assessments and management plans are reviewed and updated following risk incidents.

The provider should ensure that there are thorough weekly checks of emergency equipment and what is checked is clearly documented.

The provider should ensure emergency equipment is calibrated properly to make sure it is fit for purpose.

The provider should ensure that ligature risk assessments identify all ligature anchor points and that there is proper management of ligature risks.

Care Quality Commission

The Whittington Hospital NHS Trust

Child and adolescent mental health wards

Detailed findings

Name of service (e.g. ward/unit/team)	Name of CQC registered location
CAMHS Wards	The Whittington Hospital

Requires improvement

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

Summary of findings

We rated safety for CAMHS inpatient services as **requiring improvement** because;

- Patients' risk assessment and management plans were not always updated after an incident, which meant that staff might not be aware of new risks affecting the patient.
- The oxygen cylinders were stored on the top of a tall cupboard; there was no footstool readily available to aid access to this life saving equipment.
- There was no clear label on the emergency resuscitation bag. This might cause delay in locating it.
- Staff had completed daily checks on the emergency equipment to make sure it was fit for purpose. However, it was unclear what equipment had been checked. There was incorrect calibration of the equipment used to check the physical health of patients. There was a risk that the recordings would have been inaccurate and staff might not have responded promptly to a decline in the physical health of a patient.
- The ligature risk assessment for Simmons House was not robust. It did not have clear plans regarding the management of all ligature anchor points on the unit. Staff undertook weekly checks on emergency equipment but the checks lacked detail. Equipment used to check the physical health of patients was incorrectly calibrated. There was no assurance that the physical health checks for patients were accurate.However, the ligature risk assessment for Simmons House was not robust. It did not have clear plans regarding the management of all ligature anchor points on the unit. Staff undertook weekly checks on emergency equipment but the checks lacked detail. Equipment used to check the physical health of patients was incorrectly calibrated. There was no assurance that the physical health checks for patients were accurate.

However:

- The environment was well maintained and clean. The service was well staffed and some members of the team had been at Simmons House for a number of years. The service was able to adjust staffing levels according to the needs of the patients and there was always medical cover.
- There was clear learning from incidents and this was apparent across the unit. Staff had been trained in safeguarding and knew how to raise alerts. Staff were encouraged to develop their skills and the unit had development days to which they invited guest speakers. Appropriate procedures were followed during and after the restraint of a patient.

Our findings

Incidents

- There was a strong focus on incident reporting and learning from mistakes.
- Prompt incident reporting was expected from all staff. There was discussion of incidents at a local level and senior management level.
- There had been one serious incident within the last 12 months, which required investigation. A root cause analysis had taken place. The investigation identified that all incidents including near misses must be reported on the trust database (DATIX); discussed with the line manager and serious incidents /safeguarding information shared with partner agencies and commissioners in a quickly.
- Another incident had occurred in November 2015.A full investigation had not taken place but a debrief of all parties had happened. The management team had thought about the actions they could take in future to prevent a similar situation. The staff member involved in the incident was able to share with us what they had learned from this incident.

Are services safe?

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

- There had been 82 other incidents between September 2014 – September 2015.Twenty nine of these incidents had been due to patients exhibiting abusive and violent behaviour. One incident had been categorised high risk of long-term harm. This had been investigated.

Cleanliness, infection control and hygiene

- There was a cleaning rota in place. The environment was clean and well furnished. The audits of cleaning showed high scores for cleanliness.
- The clinic area appeared clean; however, the fridge in the clinic room appeared to be a little unclean at the bottom.
- Staff used reusable medicines pots and washed them. There was no soap or washing up liquid in the clinical treatment room or cleaning records relating to these. Failure to clean the pots thoroughly could pose a risk of infection to patients.

Environment and equipment

- The environment was well maintained and clean. Each inpatient had their own single bedroom, which had ensuite bathroom facilities.
- The unit had some blind spots, where staff would not be able to observe patients easily. There was no closed circuit television (CCTV) inside. This was a conscious decision taken by the unit, as they did not want the environment to feel institutionalised. Only four of the patients' bedrooms could be easily observed from the nurses' station and two of the patients' bedrooms were on a different floor.
- The staff were highly visible throughout the unit during the day and undertook a minimum of hourly checks on patients throughout the night. The doors to the patients' bedrooms were solid wood and did not have observation windows. As a result, staff had to open the patients' doors to check on their welfare. Opening the doors throughout the night could have disturbed the patients.
- Simmons House had undertaken a "Ligature Assessment Report" of the environment. There was also ligature risk assessment of patient accessible areas.
- The ligature risk assessment was not thorough. The ligature risk assessment report for the bedrooms failed to identify the ligature anchor points in the ensuite bathrooms. Additionally, the ligature risk assessment report for the corridor failed to identify the ligature anchor points on the windows.
- Staff recorded the ambient room temperature in the clinic room on a daily basis.
- The weekly emergency equipment check was not robust. The records of checks lacked detail and did not clearly state what items had been checked.
- There was no clear label on the emergency bag, which might cause delays in locating it.
- The emergency bag only contained one single patient use adult sized manual resuscitator. No paediatric size was available. It was important for this to be available as the unit had patients aged 13 upwards.
- There was only one set of pads for use with the defibrillator machine, therefore only enough for one use. Ideally, spare pads should be available in case of equipment failure.
- Blood pressure machines were available but only had adult sized cuffs, which meant that the readings might not necessarily be accurate in a small patient.
- Oxygen cylinders were stored unsafely on the top of a tall cupboard and no footstool was readily available to aid access.
- Two pulse oximeters, used to measure the amount oxygen in the patient's blood, were available but the calibration dates were missing on one of them.
- The calibration sticker was absent on the alcohol measuring meter. There was therefore, no assurance that the machine was accurately recording whether the patient had consumed alcohol.
- There was incorrect calibration of the blood glucose monitoring machine. The wrong code had been inputted into the machine. This meant that the blood glucose measurements taken for patients might have been incorrect.

Medicines

- There were records of the patients' allergies on the 12 drug charts we checked.

Requires improvement

Are services safe?

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

- There was evidence seen on the drug charts that when medicines were given later than prescribed, the time that the dose was administered was stated on the drug chart.
- Where there were missed doses of medicines, the majority of drug charts had an explanation recorded.
- Medicine prescribing guidelines (BNF) were available for both children and adults.
- There were daily records of the medicines fridge temperatures. It was unclear that staff were aware of how to reset the temperature of the fridge. We observed that the maximum temperature was 12°c, which may not have been the optimum temperature for the medications stored in the fridge.
- Emergency drugs were stored in the clinical treatment room in an unlocked cupboard. Needles were also stored in this cupboard, which could pose a risk of needle stick injury to staff.

Records

- We looked at seven care records. We noted that patients had copies of their care plans.
- There were two processes for recording risk information. There were on-going risk assessments recorded using a paper based risk assessment tool (RAT) and records held on the electronic database.
- Two records did not have up to date risk information on the electronic system or the paper based system. One record had inaccurate information regarding the detained status of a patient. There was information in the notes regarding the patient's aggressive behaviour but no clear plan as to how to manage the risk of aggression. The patient had been at Simmons House for four weeks. Another patient had self harmed in October 2015, but there was no updated risk assessment. The patient was on increased observation however, there were no dates recorded and there was no review.
- Two patients had been at Simmons House for four weeks. These patients had electronic risk information recorded but no RAT.
- A nurse we spoke with was unclear where the RAT was stored. We had to request the assistance of one of the doctors to locate them.
- The use of two methods of recording risk information and lack of up to date information increased the likelihood of error for staff

Safeguarding

- Staff told us about the safeguarding arrangements. Concerns regarding safeguarding were discussed during handover meetings or earlier, if necessary.
- Simmons House had an open and transparent culture and staff were encouraged both formally in supervisions and in various staff meetings to share concerns.
- All clinical staff were trained to Safeguarding Level 3. Other staff were trained to Safeguarding Level 2.
- The service manager was the safeguarding lead at Simmons House. He worked closely with the safeguarding lead for the trust. He was the designated social worker as the other social worker was on a career break. The service manager led on child protection issues within Simmons House and worked closely with the staff group to manage issues of safeguarding, including raising concerns with family members.
- The unit reported all safeguarding concerns to the trust and the local authority.
- Patient safety was a priority when they had visitors at the unit. Staff made a decision about the suitability of visitors. For example, some relatives were not allowed to have contact with patients. Photos of these individuals were available to assist staff in identifying them and ensuring that they did not come into the unit. Staff also thought about patients who had visits from older partners. They used guidance from Barnardo's to reduce the risk of child sexual exploitation.

Mandatory training

- There was a wide range of mandatory and statutory training for staff
- Safeguarding children training was mandatory. There was 100% completion of this training. Staff had also been trained in manual handling and fire safety; this was provided during the two week induction period.
- Infection control training had been completed by 84% of nursing staff.
- Staff had been trained how to restrain patients safely.

Are services safe?

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

- Band 5 nurses were able to undertake mentorship training to help them develop their knowledge and skills in teaching, learning and assessing others.
- The unit had development days three times a year. Guest speakers attended and provided training to the team.

Assessing and responding to patient risk

- There was careful consideration and planning for new patients coming into Simmons House. The unit accepted patients detained under the Mental Health Act. The team considered whether they could safely manage a patient within the unit or whether there was a more appropriate service for them.
- If the needs of a current patient exceeded current service provision, they would be transferred to a more suitable unit. For example, the staff stated that they were unable to provide care and treatment to patients who needed high levels of observation over significant periods of time.
- Staff discussed patient risk during staff handover meetings. Nursing staff and members of the MDT attended these meetings. There was information shared regarding the mental state of the patient, physical health needs and the levels of observation required to keep the patient safe.
- One patient had engaged in risky behaviours and staff planned to meet with this individual to discuss this.
- Patient care records included information about risk. However, on two of the patient records we reviewed, the risk information was not up to date. The lack of current risk information on the care records meant that staff might not be aware of patient risk.
- NICE guidelines for rapid tranquilisation were being followed.

Staffing

- The staff group was quite stable with a number of members of staff having been at Simmons House for a number of years.
- Between April 2014 and March 2015 the unit had not used any locum doctors. There was very little use of agency nurses.
- Staffing levels were able to meet the needs of the patients within the unit.
- There were three nursing vacancies at the time of inspection.
- There were always at least two qualified nurses on shift during the day and one qualified nurse at night. The ward manager was able to adjust the nursing staffing level in response to any increased patient need.
- There was always medical cover by a Senior House Officer, with support from a registrar and a Consultant during working hours (Monday to Friday 9am – 5pm).
- Out of hours, there was a duty doctor available based at Highgate mental health centre.
- There was a well-staffed MDT, which included psychologists, social workers and teachers working at Simmons House, who were able to provide a range of therapies and educational activities for the patients.

Restraint

- Nursing staff used the PROACT-SCIP model of restraint. It aimed to support staff to identify patient triggers and recognise early behavioural indicators that could lead to challenging behaviour. Other staff, e.g. teachers, used breakaway techniques.
- The staff had used restraint 11 times between December 2014 – December 2015.
- There was a restraint log documenting details of restraints, including how many people were involved, and if any patients or staff were harmed.
- The staff did not use prone restraint. If they felt they could not restrain a patient safely, they called the police for assistance.
- There was evidence that staff used the least restrictive measures and used de-escalation techniques to diffuse situations.
- Patients had reassurance and support offered during and after restraint. If there were concerns regarding potential injuries to patients or staff after a restraint, a member of the medical team checked the individual after the incident.

Are services effective?

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

Summary of findings

We rated effective as g**ood** for inpatient CAMHS because:

The service was young person focussed and recovery orientated. Staff completed comprehensive assessments of patients after admission. These assessments included patients' physical health and referrals were made to specialists when necessary.

Both the patient and their families were offered therapy sessions. NICE guidance was considered when prescribing medication. The service used specialist therapeutic interventions recommended by NICE. The unit used outcome measures to monitor the progress of patients.

There were regular meetings for staff, which gave them the opportunity to reflect on the work they undertook with patients. Staff members had regular supervision and appraisals.

The unit met the nutrition and hydration needs of patients fully.

The Royal College of Psychiatrists' Quality Network accredited Simmons House as "excellent".

Our findings

Evidence-based care and treatment

- Staff described the service as young person focussed and recovery oriented. There was a notice board in the communal areas. This displayed useful information to support the recovery of the young people.
- The service's last routine outcome measurement report completed by the Royal College of Psychiatrists' Quality Network for Inpatient CAMHS (QNIC) accredited Simmons House as excellent.
- Staff considered National Institute of Clinical Excellence (NICE) guidance when prescribing medication.
- The service used many specialist therapeutic interventions recommended by NICE for patients within CAMHS services including family therapy, mentalisation, dialectical behavioural therapy and cognitive behavioural therapy.
- Care records showed the use of outcome measures. This allowed the service to monitor a young person's progress in a systematic way. Patients were also encouraged to monitor their own progress and identify the positive changes they had made.
- Staff made appropriate referrals to physical healthcare services.

Assessment of Needs and Planning of Care

- Staff carried out comprehensive assessments of patients on admission to the ward. The assessment included a physical examination. Patients with physical health problems had referrals made to specialists.
- The team worked together to formulate care plans. Each patient had two allocated keyworkers as well as a range of other staff supporting them. This team included medical staff, teachers and psychologists.
- Individual and group therapies were offered based on the individual need of the patient.
- The unit had a mixture of electronic and paper based records.
- Care records were stored securely. All the staff we spoke with, except one member of the nursing team, knew the location of the records. This individual was unable to locate the up to date risk assessment information.
- There was personal patient information on a white board in the nurses' office. Patients who walked passed the office could see this information. This was brought to the attention of the staff. This information was no longer visible when we returned on the 17th December 2015.

Nutrition and hydration

- Staff had access to a dietician , who was able to give advice regarding patients who had specific dietary needs.
- Young people said that the food was usually good and they were able to access hot drinks and snacks.

Are services effective?

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

- Patients had fed back that they had been unhappy with the breakfast. The unit had responded by providing patients with a choice of breakfast. Patients also attended a food steering group meeting and were able to give their opinions about the menus.
- Patients of different cultures and religions had their dietary needs met.
- The unit accepted patients with eating disorders. Staff were aware of guidance around nutrition and hydration (Junior Marsipan) for this group of patients.

Patient outcomes

- The service measured outcomes for the young people using tools such as health of the nation outcome scales for children. Staff actively encouraged the involvement of the patient and family in setting treatment goal.
- Patients were encouraged to monitor their own progress, the use of a self-assessment questionnaire.

Competent staff

- Staff working across the unit included psychiatrists, clinical psychologists, nurses, teachers, support workers and social workers.
- Half the nursing team had experience of working in CAMHS prior to working at Simmons House. All qualified nursing staff were expected to apply for the mentorship programme at Middlesex University.
- New staff attended the trust induction programme and shadowed colleagues for two weeks before they were allowed to work independently. This ensured that they had a good understanding of their role and the needs of the patients at the unit.
- Staff had regular supervision and appraisal.
- There were regular reflective practice meetings that provided staff with the opportunity to think about the work they undertook with patients.
- Nurses had regular weekly team meetings.

Multi-disciplinary working

- The team included nurses, social workers, psychologists, occupational therapists, support workers, teachers and medical staff.This meant that there was a range of professionals in the team.
- Staff felt their professional view and voice was respected and that the multi-disciplinary team (MDT) worked well.
- There were handover meetings every day. The handover meeting we observed showed active participation of staff from a range of professional backgrounds. There was good discussion of patients' risks to themselves and others and actions required to minimise these risks as well as a holistic discussion of the patients' needs. Staff demonstrated a high level of care and compassion for people through their interactions and behaviour in the handover.
- Staff tried to maintain good working relationships with the local authority and the patient's care co-ordinators.
- Specialist pharmacist input was available at the unit.

Seven day services

- Simmons House was a seven day service. Some patients went home at weekends.

Adherence to the MHA and MHA Code of Practice

- The majority of staff showed a good understanding of the Mental Health Act, Code of Practice and guiding principles.
- There were two detained patients under the mental health act on the unit. Patients had their rights explained to them on admission.
- One medication chart did not have the patient's T2 attached. We discussed this with a member of the nursing team who did not appear to understand that they had a legal responsibility to check that all paperwork was in order before they administered medication to the patient.
- NYAS provided the independent mental health advocacy (IMHA) service. They attended Simmons House once a week. Posters displayed in the reception area, advertised the IMHA service. Staff notified the IMHA service regarding any patients who were being detained under the mental health act so that these patients could be supported.

Good practice in applying the MCA

- Staff understanding of Gillick / Fraser competencies was good, in deciding whether a young person under the age of 16, was able to consent to treatment without the need for parental permission or knowledge.

Are services effective?

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

- Patients were involved in decision making as far as possible. Young people gave their consent regarding any information, which would be fed back to their parents about their treatment and progress. Where patients requested staff did not share information with their parents, this was discussed within the relevant staffing team, along with the patient to understand why the patient did not want the information to be shared and to talk through the pros and cons of any decision.

Good

Are services caring?

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

Summary of findings

We rated caring in CAMHS inpatient as **good** because;

Staff demonstrated compassion and caring for the patients and their families. The language to and about the patients was respectful. Patients felt safe at Simmons House. They were complimentary about the majority of the staff and felt staff cared about their well-being. Young people contributed to their care plans and were fully involved.

The parent we spoke with thought the staff group were supportive. They had considered her views during the care planning process.

Staff recognised the patients' cultural and religious needs.

Our findings

Compassionate care

- Staff demonstrated compassion, kindness and respect for the patients and families they worked with. They had a good understanding of the background of the patients at Simmons House.
- We observed that language used by staff both about and to the patients was always respectful, considered, supportive and sensitive.
- One parent/carer described the staff as "great" and were doing their best to support their child. They felt that their child had made progress whilst at the hospital and had become more confident.
- All the patients we spoke with said that they felt safe at Simmons House. The staff were visible throughout the unit and one patient said that it was always easy to find staff.
- The patients were mainly positive about the staff and said that they prioritised patient contact over paperwork.
- Two patients commented that sometimes agency/bank staff appeared disinterested in patients and did not appear to care.

Understanding and involvement of patients and those close to them

- One patient stated that they had been able to have a tour of Simmons House before they were admitted and this had been very helpful in them settling into the hospital.
- Regular community meetings took place for the patients and staff. These meetings gave the patients the opportunity to discuss the things that concerned them. There were records of these meetings made available to those who wished to refer back to them.
- All the patients we spoke with had a care and treatment plan. The patients stated that they had been able to contribute to their plans. One young person stated that he did not like the wording on his plan and had asked the staff to change it, which they did.
- Two patients said that they and their parents had a family worker who supported them. They said that their families were very involved in their treatment and had been invited to meetings to discuss their care and treatment.
- There was a Young Person's Council held fortnightly and patients were able to give feedback to the hospital management. The young people had requested that they change the type of toilet paper provided and had requested a new snooker table through these meetings, which the hospital had done.

Are services responsive to people's needs?

Good

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

Summary of findings

We rated responsive as **good** for CAMHS inpatient because;

Patients were supported with their cultural needs and religious needs. The unit was able to admit patients who had impaired mobility.

Discharge plans started at the point of admission. When patients went home on leave, their in-patient bed was kept for them.

Patients were encouraged to air concerns and there was a clear complaints procedure. The staff considered patient feedback and the unit had made improvements as a result. There was support from a young person's advocacy service and they visited the unit regularly.

There was good education provision at Simmons House. There was an expectation that all patients would participate. The range of activities at the unit was good.

Our findings

Access, discharge and bed management

- The average of length of stay for patients at Simmons House was six to nine months.
- The admissions to the units were planned in the majority of cases. Before admission, patients could visit Simmons House. This was helpful in assisting the patient in settling onto the unit.
- The unit accepted up to four patients in an emergency. The consultant assessed each patient prior to any admission.
- When patients went home on leave, their in-patient bed was kept for him or her.
- Plans for discharge started at the point of admission. Patients were encouraged to identify the goals they wanted once they left Simmons House.
- Where appropriate, there were discharge meetings with the patient, parents/carer, staff at Simmons House and the patient's care co-ordinator. The majority of patients were discharged to the community.

Meeting people's individual needs

- There was information in reception about the advocacy service.
- In the reception area, there was information about Simmons House values, equality and diversity and leaflets about complaints.
- There was a brightly decorated main entrance to the unit, which was welcoming. It had posters designed by the patients displayed on the noticeboard.
- The service was able to access interpreters where needed to engage non-English speaking patients and families.
- The unit met the cultural and religious needs of patients. Halal and Kosher food could be provided upon request.
- Religious festivals were recognised and celebrated.
- There was adequate access for people with physical disabilities to access the service. There was lift available for patients to access the bedrooms on the first floor. One bedroom was for patients who had impaired mobility.

The ward optimises recovery, comfort and dignity

- Simmons House had a full range of rooms to support treatment and care of patients, which included therapy rooms.
- The unit had a 'quiet room' for young people to use if they were feeling distressed or wanted some quiet time.
- Each patient had a separate bedroom with en-suite facilities. The patients were able to personalise their bedrooms to make it more comfortable. They had secure storage space provided.
- Patients had mobile phones if they wished. They were not allowed televisions in their bedrooms but could use their own computers it they had them.
- The décor at Simmons House was fresh and bright. There was ample space inside. The furniture was clean and in good condition.
- There were activity and relaxation spaces on the unit. Toys, books, board games and DVDs were available for the patients to use.The unit was in the process of converting a room into a gym for the patients.

Are services responsive to people's needs?

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

- There was a school on site and the patients were expected to attend school at least two hours per day during the week up to a maximum of 25 hours per week. OFSTED had rated the school as "good" in 2014 and described the work undertaken by the educational teams as "outstanding".
- Patients were encouraged to plan their educational goals every six-eight weeks. The education team also contributed to the patients' care plans.
- The unit had a secure garden. Staff made efforts to make this a nice space to be in with comfortable seating areas. For patients who were interested in gardening there were raised beds for activities such as growing food and we were told these were used as part of the planned education.
- Patients were involved in the planning of menus; they were also able to give feedback regarding the quality of food through attending the regular "food steering" meeting.

Learning from complaints and concerns

- We were told the service rarely received formal complaints. Staff said they try to resolve issues raised locally where possible.
- The trust had a central log of formal complaints. Patients were able to log informal complaints and concerns directly to the management at Simmons House. For example, in April 2015, a patient made a complaint about a member of staff, this was taken seriously and reviewed thoroughly. The management empowered patients to enable them to feel confident to make complaints and believe that their issues listened to or resolved.

Are services well-led?

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

Summary of findings

We rated well-led as **good** for CAMHS because;

The staff reflected the values of the trust. They were committed to the work they undertook with patients and their families. The governance structures were robust and there were clear processes to monitor the quality of the work undertaken by the team.

There was a culture of openness and transparency at Simmons House. The team were supportive of each other. Staff said they felt listened to and supported by their managers. There was clear leadership at a local level, however, some staff members stated that they felt a little distanced from the trust.

There was a commitment to continued improvement and Simmons House was accredited as “excellent” by the Royal College of Psychiatrists’ Quality Network for inpatient CAMHS.

Our findings

Vision and strategy for this service

- Staff members reflected the values of the trust and were committed and passionate about the work they did with young people and families. They knew who the senior staff were in the organisation.

Governance, risk management and quality measurement

- There were systems or processes established to ensure the quality and safety of the service was assessed and monitored. The governance of the service was strong and there were clear channels for reporting incidents and disseminating information. There were clear processes to monitor the quality of the service provided.
- Staff felt that there was excellent communication within the team and they were involved in discussions about the service.
- The unit had effective systems to safeguard the safety and welfare of patients. Procedures were in place to ensure team members and patients safety such as supervision and training.
- Patients’ feedback was used to address patients' concerns. There was systematic collection of patients’ views.

Leadership of service

- There was clear leadership at Simmons House.The service was strongly clinician lead.
- Staff knew there was a whistle blowing process. They talked about what they would do if they had concerns they did not feel could be raised with senior managers.
- We heard about a commitment to creating a culture of absolute transparency and an environment in which staff members felt they could raise difficult issues and share ideas. Management had forums in place for staff to express concerns in a supportive setting.
- All the staff we spoke with were complimentary about the management.
- Staff felt that stress levels were low and that management and colleagues were supportive of each other.
- Some staff had good understanding of duty of candour requirements.
- The manager routinely collected information from staff who had resigned (exit questionnaires).This information was used identify if improvements needed to be made to the working environment.Three staff had left in the past 12 months.Two nurses had left because they wanted career progression, the other nurse had left because they did not feel suited to the role.

Culture within the service

- Staff appeared professional at all times.The atmosphere at Simmons House was very young person friendly.
- Four staff members felt that Simmons House was isolated from the wider trust, which was an acute NHS trust.They identified that Simmons House was different to the majority of services provided by the wider trust and that the work undertaken by Simmons House was not always well understood.

Child and family engagement

- The service engaged with patients and families well.There was evidence that the opinions of the patient’s family were sought.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment Sufficient equipment and/or medical devices that are necessary to meet people's needs should be available at all times and devices must be kept in full working order. They should be available when needed and within a reasonable time without posing a risk. Oxygen cylinders were stored on top of tall cupboard in the clinic room. There was no footstool available. As a result there was a risk to people because lifesaving equipment was not easily accessible in an emergency situation. This was a breach of Regulation 12 (2)(f) HSCA (RA) Regulations 2014