Rhodes Wood Hospital

Quality Report

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

Ratings

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

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

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

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

Overall summary

We rated Rhodes Wood Hospital as good overall because:

- The environment was visibly clean and homely. Furnishings had been chosen to create a child friendly atmosphere.
- Risks relating to ligatures had been identified and mitigated against. Staffing levels were based upon occupancy and acuity levels which were monitored regularly by ward managers and senior staff.
- All staff had received level 3 safeguarding training and there was a designated safeguarding lead social worker who had established links with the local authority safeguarding officer (LADO) to review all safeguarding referrals and concerns.
- The service offered specialist training on eating disorders to all staff.
- There were robust reporting systems in place for staff to learn lessons from serious incidents and to respond to complaints.
- Comprehensive risk assessments and care plans were completed pre-admission through to discharge and reviewed weekly and when an individual patient's presentation changed.
- There was a large multi-disciplinary team which offered family therapy, psychology, psychotherapy, dietetics, nursing and psychiatry. The MDT attended a daily handover to have up to date information on patients.
- The care model was clearly defined and followed National Institute for Health and Care Excellence guidance for eating disorders including the use of the Junior MARSIPAN (management of the really sick patient with anorexia nervosa under 18's).
- Feedback from patients and their families was generally positive. There were support groups offered for families fortnightly.
- Following discharge the service routinely offered a 12 week follow-up package of care which supported the patient and their family to adjust to the community setting and allowed weekend access to the service for more intense support where appropriate. Patients were routinely offered an innovative therapeutic intervention called cognitive remediation therapy (CRT) to all patients during their admission at Rhodes Wood hospital. This intervention had been published in a psychology journal.

However:

- We found some medical equipment to monitor physical healthcare was not recently calibrated or was out of date. This was resolved at the time of the unannounced visit.
- We found that prior to January 2017 not all qualified staff had received regular supervision.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Child and adolescent mental health wards	Good 	Good

Summary of findings

Contents

Good

Rhodes Wood Hospital

Services we looked at
Child and adolescent mental health wards;

Summary of this inspection

Background to Rhodes Wood Hospital

Rhodes Wood Hospital is a registered location under the provider of Elysium Healthcare Limited. The hospital provides care and treatment for child and young people aged between six and 18 years of age who have a primary diagnosis of an eating disorder. The maximum amount of patients at Rhodes Wood Hospital is 30. At the time of inspection, there were 25 patients. There was a registered manager in place and the service is registered for treatment of disease, disorder or injury, assessment or medical treatment for persons detained under the Mental Health Act 1983, diagnostics and screening procedures under the Health and Social Care Act 2008.

Children and young people at Rhodes Wood Hospital receive treatment informally or under a section of the Mental Health Act 1983. There were ten children and young people subject to detention under the MHA at the time of inspection.

Rhodes Wood Hospital has not been inspected since registering with the Care Quality Commission on 10 October 2016 following a change of provider. Previously it was inspected on 12 and 13 May 2015 under a different provider and known as Rhodes Farm Clinic. The inspection was routine and received a good rating overall.

There were no compliance actions identified at the last inspection.

Our inspection team

Team leader: Vanessa Kinsey-Thatcher-Inspector

The team was comprised of three CQC inspectors, two specialist advisors; one was a social worker with experience of working with young people and a child and adolescent consultant psychiatrist with experience of working with young people with an eating disorder and an expert by experience. An expert by experience is a person who has personal experience of using, or supporting someone using a specialist eating disorder service.

We would like to thank the staff, patients and carers who spoke to us about their experiences during the inspection.

Why we carried out this inspection

We inspected this 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 this service. We asked a range of other organisations for information and asked the provider to submit training figures and other information.

During the inspection visit, the inspection team:

- visited all four wards at Rhodes Wood Hospital.
- spoke with 13 patients
- spoke with two sets of parents

Summary of this inspection

- spoke with three managers for each ward
- spoke with three qualified nurses
- spoke with six therapeutic support workers
- spoke with two kitchen staff and maintenance staff
- spoke with eight members of multidisciplinary staff
- spoke with two consultant psychiatrists
- interviewed the hospital director who was the registered manager with overall responsibility for these services
- looked at eight human resources files
- observed three individual clinical review meetings
- observed a community meeting
- six comments cards were filled in by young people.

We also:

- looked at 15 care records of people who use the services
- looked at 17 medication charts
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

The patients using the service were positive about the service and the care they received.

They were able to raise concerns and complaints via the patients' council or advocacy and felt staff responded quickly to resolve issues.

The patients at Rhodes Wood Hospital were able to contribute to service development via the patients' council, which met regularly and was facilitated by an expert by experience.

Some patients we spoke to were unhappy with the time limited phone calls to family in the evenings and this view was also expressed within the comments cards.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as good because:

- The environment was visibly clean. Furnishings and décor was in good condition and homely.
- Staffing levels were based on occupancy and acuity levels. Agency and bank staff received the same induction to the service as permanent staff.
- There was a risk assessment in place for the management of ligature risks for the internal environment.
- All three wards had the ability to create a single sex lounge as they had a secondary room with sofas and chairs in them. Mymwood place was not currently occupied as a ward however it was used for therapy and community meetings by the young people during the day.
- Management and staff knew how to raise a safeguarding concern; they had received level three safeguarding training. There was a social worker employed by the hospital who had established links with the local safeguarding authority officer to ensure safeguarding referrals were dealt with appropriately.
- The hospital had a robust reporting system in place for incidents and there was evidence of lessons learnt from these incidents.
- There were fully equipped clinic rooms with temperature monitoring and medicine trollies. There were regular medicine management audits and the outcomes were feedback to staff and managers.
- The hospital used a specialised restraint technique for children and young people and all staff who were eligible had received restraint training. All restraints were recorded and audited to look at reducing the amount of restraint used.

However:

- We found that there were no paediatric cuffs being used to measure young people's blood pressure and that other clinical equipment was not recently calibrated or was out of date. This was resolved at the time of the unannounced inspection.
- There were no hand towel dispensers in the clinic rooms.
- Staff reported that there were not enough pagers for all staff to alert the other wards that assistance was needed.

Are services effective?

Good

We rated effective as good because:

Summary of this inspection

- All 15 patient care records were up to date and comprehensive. The care plans were personalised, holistic and goal oriented.
- The team used multiple outcome measures throughout the admission and treatment process to gauge the progress of the young person and monitor the effectiveness of the care package. The hospital offered a 12 week follow–up package post discharge to reduce the risk of relapse.
- Rhodes Wood hospital used the Junior MARSIPAN (management of really sick patients under 18 with anorexia nervosa) and the National Institute of Clinical Excellence guidance for treatment of over 8's with an eating disorder.
- Training compliance with the Mental Capacity Act was 76% however not all staff we spoke with were clear in the use of the five guiding principles.
- Capacity to consent was routinely recorded making reference to Gillick competency.
- The hospital worked effectively within a multi-disciplinary team and specialist training and induction was provided for staff in eating disorders.
- Staff on Cheshunt and Ridgeway wards had received an annual appraisal. Since January 2017 staff had received regular clinical supervision.
- The hospital carried out regular clinical audits and the findings were feedback to staff via action plans following discussion in the clinical governance meetings monthly.
- The hospital had a wide range of professional disciplines within the multi-disciplinary team. The MDT met weekly and attended a ward handover every weekday morning.

Are services caring?

Good

We rated caring as good because:

- We spoke to 13 young people and most of them spoke positively about the service.
- Young people were able to represent the voice of the patient through the Rhodes Wood patient council. Young people contributed to the development of the service including menu reviews, future participation in interview panels for staff recruitment and activities provided on site.
- Parents and carers spoke highly of the service and the support it offered them and felt able to raise complaints if necessary.
- We observed that staff were kind and respectful when interacting with young people and when discussing them in handovers and meetings.

However:

Summary of this inspection

- Five young people we spoke to were unhappy with the time limited phone calls to family in the evening.

Are services responsive?

Good

We rated responsive as good because:

- Referrals and admissions were planned and monitored through NHS England specialist commissioning arrangements.
- The service provided a 12 week follow-up programme for patients after discharge and liaison with the local services was evident.
- The service provided multiple therapy rooms and meeting rooms for individual or group therapy to take place.
- Complaints were logged centrally with the hospital director or ward manager and were responded to within 7 days initially and a final response within 28 days.

Are services well-led?

Good

We rated well-led as good because:

- Staff demonstrated the visions and values of the service and felt supported by their managers and colleagues.
- The hospital director had an in-depth knowledge about the challenges the hospital were facing and demonstrated that frequent audits and incident monitoring were informing how the service was trying to address recruitment issues and serious incidents.
- The service had a very strong focus on quality improvement. They had a recent peer review by the quality network for in-patient for child and adolescent mental health services CAMHS at the Ridgeway unit and had secured funding for a psychologist to undertake a doctorate in cognitive remediation therapy which was offered as a treatment intervention for all patients at Rhodes Wood hospital.
- Supervision was provided both individually and in group format. From 1 April 2016 to 31December 2016 the service reported that 85% of staff were receiving regular supervision. However, we found that not all qualified nurses had received regular supervision prior to January 2017.

Detailed findings from this inspection

Mental Health Act responsibilities

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

Overall Nursing staff had received mandatory training in the Mental health Act and the Mental Health Act Code of Practice. Consultants were Section 12 approved psychiatrists. There was a Mental Health Act Administrator on site. Patients subject to detention had their rights read to them in accordance with section132 and repeat attempts were made to ensure they understood their rights.

At the time of inspection we spoke to the patients independent mental act advocate (IMHA) who visited the hospital on a weekly basis to support patients subject to detention under the act.

Seventy-nine per cent of clinical staff had received training in the Mental Health Act.

Mental Capacity Act and Deprivation of Liberty Safeguards

The Mental Capacity Act (MCA) does not apply to young people aged 15 and under. For children under the age of 16, staff applied the Gillick competency test. This recognised that some children might have a sufficient level of maturity to make some decisions themselves. Most staff at Rhodes Wood Hospital had received training in the Mental Capacity Act and the relevance of Gillick competency in the under 16's.

There were no Deprivation of Liberty safeguards as this legislation only applies to those over 18 years of age.

CQC have made a public commitment to reviewing provider adherence to Mental Capacity Act and Deprivation of Liberty Safeguards.

Overview of ratings

Our ratings for this location are:

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

Good

Child and adolescent mental health wards

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

Are child and adolescent mental health wards safe?

Good

Safe and clean environment

- We found that there was a risk assessment in place for the management of ligature risks for the internal environment. We found that the ligature risk assessments were last updated on the 27 January 2017. Managers told us they were updated on a monthly basis. A ligature anchor point is an environmental feature or structure, to which patients may fix a ligature with the intention of harming themselves. However, we found two fixed ligature points at the time of inspection. This was brought to the attention of the manager at the time of inspection and both of these were removed or access to them restricted immediately. There was no ligature risk assessment for the external parts of the building. Staff mitigated the risk by patients always being escorted by staff at all times when outside.
- The hospital is accessed via a secure intercom system. Staff had key fobs which allowed them access to all parts of the hospital. There was a signing in book for visitors present on each ward.
- Bedroom accommodation was either single or shared. Males were accommodated in single sexed bedrooms away from female bedrooms with staff offices in between. All rooms had en-suite facilities.
- During inspection it was noted that neither Cheshunt nor Shepherd ward ground floor nursing offices had observation panels in the doors. On the follow up unannounced visit we saw that large observation panels with internal blinds which were observed to be open at the time, had been fitted to both office doors.
- All three wards had the ability to create a single sex lounge as they had a secondary room with sofas and chairs in them. All three wards offer mixed sex accommodation due to the ages of the patients. There were several bedrooms that accommodated two or three patients but only by the same gender. Staff said it was helpful to the patients to share a room as they were away from their home.
- There was a clinic room on every ward. On Ridgeway ward there was a separate clinical room for naso-gastric feeding. Each nursing office had emergency resuscitation equipment including ligature cutters, emergency drugs, defibrillator and oxygen. The emergency equipment was in date and was audited on a weekly basis.
- In both the clinic room on Ridgeway ward and Mymwood place we found that some equipment was out of date. This included vacutainers for taking blood, scales that had not been calibrated within the expected timescales and bandages that had past expiration dates. These issues were raised at the time of inspection and immediately resolved.
- It was noted that there were no paediatric blood pressure cuffs in situ on the electronic dina-map blood pressure machines. The staff were using a standard adult cuff which meant that the blood pressures taken may not have been accurate for younger patients or those with very low body weights. This issue was raised at the time and on the follow up visit, the paediatric cuffs were visible on the machines.

- All four clinic rooms were visibly clean however there were no stickers to indicate when the equipment was last cleaned. There were cleaning rotas in place and housekeeping staff employed. There was evidence of audits in relation to the environment including furniture, water testing and infection control.
- The environment at Rhodes Wood Hospital was visibly clean and well decorated. The furnishings included sofas and cushions and were child-friendly.
- There was a nurse call button system throughout the wards so when staff needed extra assistance it could be summoned. Staff reported that there were not enough pagers for all staff to alert the other wards that assistance was needed.
- There were handwashing sinks and soap available in clinical areas. However, there were no hand towel dispensers mounted to the walls. Paper towels were stored on the surfaces which meant they could become contaminated easily.
- Rhodes Wood Hospital had fire extinguishers in place that were checked annually by an external company. A fire policy was in place. We saw evidence of regular fire testing and evacuation procedures with learning outcomes following these.
- We found that closed circuit television (CCTV) cameras were fixed to walls externally to the building for security purposes. There were no internal CCTV cameras on the wards.
- The hospital had a maintenance person in place that worked full-time and undertook environmental risk assessments and carried out repairs on site.

Safe staffing

- Staffing levels had been determined by the hospital director looking at occupancy levels and acuity. Staff told us there had been two occasions that Shepherd ward had been short staffed. There was a qualified nurse present on every shift across all three wards 24 hours per day. At the time of inspection the hospital used regular bank and agency nursing staff to cover vacant shifts. Managers told us they could request extra staffing based on the needs of the ward.
- The hospital used several agencies to fill the shifts. Agency nurses undertook the same induction and mandatory training as the substantive staff.
- Rhodes Wood Hospital moved location from London to Hertfordshire in March 2016. This meant that there had been a substantial turnover of staff and new staff joining the service due to its expansion. The hospital had 14 staff leave between 1 January 2016 to the 28 March 2016. Overall vacancies for Rhodes Wood hospital were 14 per cent at the time of inspection. Each ward had one full time nurse manager in post at the time of inspection. Vacancies for qualified nurses at the time of inspection were six whole time equivalents which were being advertised and four posts had been recruited to. There was a vacancy for a part time administrator and a consultant psychiatrist. There were no therapeutic support worker vacancies. The hospital provided a shuttle bus to the local area to support staff coming to work as the location of the hospital was quite remote.
- Overall sickness levels for clinical staff was five per cent for Shepherd ward and Ridgeway unit and three per cent for Cheshunt ward from 29 March 29016 to 31 December 2016. Sickness and absence was managed according to the provider's policies.
- Mandatory training was provided for all staff including bank and agency. Training included children's safeguarding level 3, basic life support including the use of defibrillators and cardiopulmonary resuscitation, infection control, de-escalation and breakaway, food hygiene, emergency first aid and Mental Health Act training. Compliance levels were all between 75% and 100% except for equality and diversity which was 74%, security course 73% and Mental Capacity Act/ Deprivation of Liberty safeguards which was 76%.

Assessing and managing risk to patients and staff

- Staff undertook risk assessments on all patients prior to on admission, this included assessing risks to the patient's physical health. We looked at 15 care records and found that all of them had completed comprehensive risk assessments.
- Rhodes Wood Hospital employed three consultant psychiatrists who undertook physical healthcare observations on admission and a full physical examination. We found evidence that physical healthcare observations are taken in accordance with the doctor's recommendations.
- The service had a number of rules which were known and understood by the patients. For example young people could not have mobile phones or access to the internet, other than at school. There was access to a phone in the evenings and allotted time slots for young people to contact their family and carers. Some of the

comments made by the young people were about the rules and how strict they were. Staff told us these rules supported the treatment programme to ensure the young people continued to recover from their illness.

- The service did not use seclusion and there are no seclusion rooms in the hospital.
- Staff were trained in techniques of restraint called PRICE (protecting rights in a caring environment). This technique promoted positive behaviour support and de-escalation. Staff told us restraint most often occurred when a young person required naso-gastric feeding. We saw staff record incidents of restraint and the reasons why. There were a total of 438 restraints between 1 July 2016 and the 31 December 2016. 313 of these restraints were relating to naso-gastric feeding or to keep the patient safe. The highest number of restraints were on the Ridgeway unit. Managers told us that they had one young person who presented with high levels of challenging behaviour and that they do not use prone restraint routinely; however there were 10 episodes of prone restraint being used to manage a disturbed patient on the Ridgeway unit. There were no prone restraints on Cheshunt or Shepherd wards and only two episodes of restraint on Shepherd ward and seven episodes on Cheshunt in the same time period.
- The service had clear policies and procedures for the observations of young people. Staff received training on this in their induction period.
- The service had clear policies and procedures for the observations of young people. Staff undertook regular observations on patients and recorded these on an observation sheet consistently. Staff searched patients when they returned from leave. They also undertook random room searches and also conducted searches after incidents.
- Due to the age of the young people and the location of the hospital we found that informal patients could not leave the hospital at will. However, the staff supported the young people to have access to the outside gardens and grounds.
- All staff 100% had completed safeguarding children level 3training and adult safeguarding level one training. The staff understood safeguarding procedures however, two staff we spoke to did not know how to escalate a safeguarding concern to the local authority out of hours.
- Medicines were stored appropriately in locked trollies and cupboards. We found there was temperature controls in place for clinic rooms and fridges. Staff, including a pharmacist, carried out regular audits and the findings were fedback to the ward managers and senior staff.
- The hospital completed a quarterly report on the use of restrictive practices including the use of observations, restraint and removal of blanket decisions for new admissions.
- Between 1 July 2016 and 31 December 2016 there were 10 occasions where rapid tranquilisation had been used. This was in relation to a young person who presented with acutely disturbed behaviour and has since left the service.

Track record on safety

- The CQC received eight notifications between 4 October 2016 and the 13 March 2017. The most recent notification was in relation to an allegation of abuse. These incidents had been fully investigated by the service. A notification related to serious injury was received in November 2016 and following investigation lessons learnt had been cascaded through to staff.

Reporting incidents and learning from when things go wrong

- The service had an on-line reporting system to record incidents. We saw evidence of weekly meetings which reviewed these incidents and the actions arising from discussion of serious incidents by the senior management team. Staff received de-briefing following incidents and we saw minutes of the incident and clinical risk meeting.
- Following a serious incident where a young person harmed themselves, a root cause analysis investigation took place and a written response was sent to the relatives.
- The lead psychologist said the multidisciplinary team attended a daily handover during the week and were able to discuss the incident with the young person during a therapy session where appropriate. A peer supervision/reflective practice group was offered to staff to provide support and to explore learning from these incidents.

Are child and adolescent mental health wards effective?

Good

Child and adolescent mental health wards

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- We reviewed 15 care plans. All of them had comprehensive risk assessments and support plans. Eleven of them included evidence of the young person using the service had contributed to their treatment plan. Care plans were up to date and reviewed by the multidisciplinary team on a regular basis. They were personalised and goal-focused, identifying strengths and were recovery-orientated.
- There was evidence of physical health care plans in place. Physical health observations such as blood pressure measurements, pulse, temperature, electrocardiograms (ECG) and blood tests had been completed and were monitored regularly.
- Confidential information was stored electronically. Staff had separate login details to ensure access was controlled and secure. Paper records such as medicine charts and observation sheets were held securely in the nursing offices.

Best practice in treatment and care

- We looked at 17 medication charts and found that the consultants prescribed within BNF limits and according to the NICE guidance for eating disorders.
- The lead psychologist and staff spoke about the cognitive remediation therapy (CRT) approach which has been published in journals as a therapeutic intervention for those young people who have an eating disorder. This intervention was offered to all young people who were receiving treatment at the hospital.
- The service followed the Junior MARSIPAN guidance as recommended by the National Institute of Clinical Excellence (NICE) in relation to monitoring the physical health of patients suffering from an eating disorder.
- Staff monitored patients' nutritional needs in line with their treatment for an eating disorder. Although there was no water available freely, this was made available according to the patients care plan and individual needs.
- The service routinely undertook nine nationally recognised outcome measures for every young person admitted. These outcome measures are nationally recognised tools including Health of the Nation Outcome Scales for Children and Adolescents for patient, parent and clinician (HoNOSCA). Staff used these outcome measures as a way to chart the progress in treatment for the young person. Recent audits of these tools evidenced the improvement to the patient's heath following treatment at the hospital.
- Staff carried out a wide range of clinical audits. These audits were conducted monthly or quarterly and we found evidence within the business meeting minutes that these audits had been completed and actions arising had been identified.

Skilled staff to deliver care

- The hospital had a full range of mental health disciplines within the multidisciplinary team. There were psychiatrists, clinical psychologists, dietitian, occupational therapist, mental health nurses, registered general nurse, trainee psychotherapist, family therapist and a social worker.
- Staff were experienced in the field of mental health with most staff having experience in working with young people who had an eating disorder. The naso-gastric (NG) feeding training provided to staff also included information on the medical complications of anorexia nervosa, proactive physical intervention techniques in assisted feeding, tube insertion techniques and refeeding syndrome. Refeeding syndrome can occur at the beginning of treatment for anorexia nervosa when patients have an increase in calorie intake and can be fatal.
- We found that all staff received a one week induction to the hospital which included teaching sessions on the language of eating disorders, relationships and boundaries, ligature cutters, self-harm and observations in an eating disorder setting. Qualified staff, therapeutic support workers, bank and agency staff received the same induction.
- We found recent records of clinical supervision for staff since January 2017 however staff told us that they were not receiving regular supervision. The service reported that 85% of clinical staff were receiving supervision between the 1 April 2016 and 31 December 2016. A manager told us this issue was being addressed and said it was due to a lack of permanent qualified staff who could deliver supervision.
- Overall 82% of staff eligible for appraisal across the hospital had received one.

Good

Child and adolescent mental health wards

Multi-disciplinary and inter-agency team work

- We observed a handover for the MDT at the time of inspection. These handovers occurred each weekday and a member of each professional discipline attended each ward. The MDT met weekly to discuss patient's care and treatment including reviewing risk and observation levels and any concerns regarding their physical health.
- Each shift had a handover meeting, which lasted for 30 minutes. These occurred for both morning and evening shift changeovers. All staff worked for a 12.5 hour shift so there was no lunchtime handover.
- Staff worked closely with the local CAMHS teams and care co-ordinators in the young person's local area. There was evidence in the notes that external professionals were invited to care programme approach (CPA) and clinical review meetings. This helped to ensure good communication regarding discharge planning and CPA aftercare.
- The hospital had established links with the local authority safeguarding officer and monthly meetings had started to take place where safeguarding alerts and concerns were discussed. If a young person was in hospital for longer than 12 weeks a notification would be sent to the local authority to inform them.

Adherence to the MHA and the MHA Code of Practice

- Rhodes Wood hospital had a full time Mental Health Act administrator in post and all staff received training in the MHA. Where renewals of sections or consent to treatment forms were required, staff had support from the administrator to ensure these forms were completed in accordance to the act.
- We saw records of section 17 leave including the conditions of the leave. All patients who were detained had leave forms that were current and in date.
- Seventy-nine per cent of clinical staff had received training in the Mental Health Act.
- Staff demonstrated a good understanding of the act. The MHA administrator undertook weekly checks of the paperwork and a monthly report was prepared for the hospital governance meeting. The provider had a legal department which staff accessed to assist with Mental Health Act Review tribunals.
- Detained patients had their section 132 rights read to them and this was recorded in their notes.
- The hospital had regular weekly visits to all three wards by an Independent Mental Health Advocate (IMHA) who met with young people to listen and support them in relation to capacity issues, tribunals and access to their notes. The patient's felt the advocate was supportive and kind to them.

Good practice in applying the MCA

- Overall 76% of staff had received training in the Mental Capacity Act. The act applies to young people over the age of 16 years. Most of the staff we spoke to understood the issues regarding capacity to consent to treatment and explained about Gillick competency in the under 16s. For younger patients, parents or carers signed a parental consent form to allow treatment to be given.

Are child and adolescent mental health wards caring?

Good

. **Kindness, dignity, respect and support**

- Interactions between the staff and the people using the service were supportive, kind and caring. Staff knew and understood each individual patient and their needs.
- We received six feedback comment cards which had both positive and negative comments from young people. Most young people we spoke with felt supported by the staff and their keyworkers. Parents and carers we spoke to said that the service was "excellent" and "had made a difference to their lives and that of their child".
- All the young people and parents we spoke with said that the phone calls home were too restrictive. Patients were allocated a 15 minute phone call at an allotted time each evening. Staff said this allocation of time had arisen from consultation with both the young people and their relatives. We found that young people were not always able to have their call in private or at their allotted time and this caused them distress at times.
- There were no mobile phones allowed at the hospital and this was to ensure that young people were not able to access the internet or external influences that may affect their treatment.

Good

Child and adolescent mental health wards

- Young people spoke highly of their keyworkers and the psychological support they received. Two parents mentioned that they would like more psycho-education for parents and carers.
- Young people told us that they wanted more fruit and that they were offered too many dairy products.

The involvement of people in the care they receive

- Young people admitted to Rhodes Wood hospital received a patient's information pack to introduce them to the hospital. Parents and carers also received an information pack with details of accommodation in the local area and model of care and treatment offered by the hospital.
- Young people had an opportunity to sit on the Rhodes Wood Patient Council which represented the views of the patients via community meetings. The young people gave an informative presentation at the time of inspection about the role of the council. Patients produced a regular newsletter that outlined the current events at the hospital and the issues that had been raised in the patient council meetings.
- Staff invited the young people to monthly individual clinical review meetings. Young people were not routinely invited into the multidisciplinary meetings although staff sought their views about their treatment beforehand. 11 out of the 15 care records showed that copies of care plans had been given to the young person.
- Young people told us they were able to see an independent advocate who was an IMHA weekly who supported them with issues regarding their detention under the Mental Health Act.
- Communication issues regarding leave and restraints were raised by two parents we spoke to who felt that at times they were not informed about these incidents at the time.
- There was a fortnightly parent/carer support group at the weekend which provided support for them. This was part of the hospital "resources to enable support in treatment" (REST) project and the group were facilitated by a family therapist.
- The hospital employed an expert by experience that provided a patient advisory liaison service (PALS). PALS supported young people regarding their care and treatment. This included the PALS person chairing the community groups and the patients' council where young people raised issues about the service.

Are child and adolescent mental health wards responsive to people's needs?

(for example, to feedback?)

Good

. **Kindness, dignity, respect and support**

- Interactions between the staff and the people using the service were supportive, kind and caring. Staff knew and understood each individual patient and their needs.
- We received six feedback comment cards which had both positive and negative comments from young people. Most young people we spoke with felt supported by the staff and their keyworkers. Parents and carers we spoke to said that the service was "excellent" and "had made a difference to their lives and that of their child".
- All the young people and parents we spoke with said that the phone calls home were too restrictive. Patients were allocated a 15 minute phone call at an allotted time each evening. Staff said this allocation of time had arisen from consultation with both the young people and their relatives. We found that young people were not always able to have their call in private or at their allotted time and this caused them distress at times.
- There were no mobile phones allowed at the hospital and this was to ensure that young people were not able to access the internet or external influences that may affect their treatment.
- Young people spoke highly of their keyworkers and the psychological support they received. Two parents mentioned that they would like more psycho-education for parents and carers.
- Young people told us that they wanted more fruit and that they were offered too many dairy products.

The involvement of people in the care they receive

- Young people admitted to Rhodes Wood hospital received a patient's information pack to introduce them to the hospital. Parents and carers also received an information pack with details of accommodation in the local area and model of care and treatment offered by the hospital.
- Young people had an opportunity to sit on the Rhodes Wood Patient Council which represented the views of

the patients via community meetings. The young people gave an informative presentation at the time of inspection about the role of the council. Patients produced a regular newsletter that outlined the current events at the hospital and the issues that had been raised in the patient council meetings.

- Staff invited the young people to monthly individual clinical review meetings. Young people were not routinely invited into the multidisciplinary meetings although staff sought their views about their treatment beforehand. 11 out of the 15 care records showed that copies of care plans had been given to the young person.
- Young people told us they were able to see an independent advocate who was an IMHA weekly who supported them with issues regarding their detention under the Mental Health Act.
- Communication issues regarding leave and restraints were raised by two parents we spoke to who felt that at times they were not informed about these incidents at the time.
- There was a fortnightly parent/carer support group at the weekend which provided support for them. This was part of the hospital "resources to enable support in treatment" (REST) project and the group were facilitated by a family therapist.
- The hospital employed an expert by experience that provided a patient advisory liaison service (PALS). PALS supported young people regarding their care and treatment. This included the PALS person chairing the community groups and the patients' council where young people raised issues about the service.

Are child and adolescent mental health wards well-led?

Good

Vision and values

- Managers spoke with enthusiasm about the visions and values of the hospital and how these values underpinned their work. Staff reflected the vision and values in their work.
- Staff were clear about the model of care and treatment provided.
- Staff knew all the senior staff at the hospital and they visited the wards regularly.

Good governance

- Staff received appropriate training and induction to undertake their roles; this included a preceptorship programme for newly qualified nurses.
- Most staff received an annual appraisal in line with the provider's policies however on Shepherd ward only 20 per cent of staff had received an appraisal.
- There was evidence within the human resources files that from January 2017 most staff were receiving clinical supervision and this was on an individual basis or through reflective practice groups. The lead psychologist and social worker received supervision externally and this was paid for by the provider. Members of the MDT were supervised by the head of psychology. We could not find evidence of regular clinical supervision for qualified nurses prior to January 2017 and the hospital director told us this issue had been raised in the clinical business meetings and there was an action plan in place to address this. Staff we spoke to said they had recently received supervision and that there were peer supervision group available.
- The hospital worked closely with NHS England commissioning group and produced an annual report which contained information about its challenges and progress over the year including involvement of service users and admissions/discharges.
- The hospital director monitored staffing levels based on occupancy and acuity levels. We saw evidence of this in the minutes of the clinical governance meetings. There were three episodes recorded in the safer staffing audit in February 2017 where staff shortages had been identified. These were addressed at the time.
- The hospital had identified eight training days to deliver additional training to staff specifically for CAMHS and eating disorders. Each nurse and therapeutic support worker had been allocated to a training cohort and the sessions had been delivered since February on a rolling programme. The areas covered were boundaries and therapeutic relationships, team work, consistency and managing difficult conversations, managing distorted thoughts-food and body image and personality disorders and autism.

Leadership, morale and staff engagement

Good

Child and adolescent mental health wards

- Staff described morale as improving and was now good. The service had experienced several changes of provider and location over the last eighteen months and this had impacted on staffing levels. A significant number of permanent staff had left due to the change in location.
- Most staff we spoke to felt able to raise concerns and to whistle blow without fear of reprisal. There were two whistle-blowing concerns raised with the CQC in the past twelve months, both of these were raised with the hospital and investigated. One related to a bullying culture and the other to low staffing.
- The hospital conducted exit interviews with staff leaving the service and the hospital director was aware of the reasons staff left. Analysis of these surveys showed that staff had left due to the change in geographical location or for career progression.
- Most staff reported feeling well supported by their managers and colleagues.
- The hospital undertook a variety of clinical audits including audits on safeguarding's, care notes and risk assessments, motivation and length of stay and infection control. The findings were fedback through the clinical governance and business meetings with actions identified with timescales.

Commitment to quality improvement and innovation

- Recently the Ridgeway unit had been peer reviewed by the quality network for in-patient CAMHS (QNIC) which is part of the Royal College of Psychiatrists college quality improvement network. The hospital scored between 98% and 100% for all areas except environment and facilities which they scored 93%. The environmental concerns related to the size of the dining room on Ridgeway. Both Cheshunt and Shepherd wards were due to be peer reviewed in May 2017 by QNIC. The hospital had created an action plan to address the issues identified.
- Funding for a psychologist to undertake a doctorate (PhD) in the use of cognitive remediation therapy (CRT) as an intervention for anorexia nervosa in young people had been obtained. This intervention was offered to every young person entering the service and had recently been published and the head of psychology was due to present at an eating disorders conference in March 2017.

Outstanding practice and areas for improvement

Outstanding practice

Rhodes Wood hospital is participating in research related to the use of Cognitive Remediation Therapy (CRT) as an intervention for patients diagnosed with an eating disorder. The hospital had been published recently in a journal and funding for a doctorate had been obtained to continue further research in this area.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that medical equipment is fit for use and appropriate for the needs of the patients.
- The provider should ensure that staff have access to equipment that supports them in responding to emergencies across the hospital.
- The provider should ensure that all qualified staff receive clinical supervision.