Newcombe Lodge

Quality Report

Newcombe Lodge
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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?	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 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 Newcombe Lodge as good because:

- The home had good indoor facilities and had a good garden. The home involved young people in decorating the home and they were encouraged to decorate their room and to personalise it. Young people were admitted from around the country. They were given the chance to visit the home and stay overnight to see if they liked the placement.
- Staffing levels had improved over the six months before this inspection. Staff said they felt supported by managers through this time and that moral was now better and the home was calmer. Governance systems had helped to address the gaps in staffing and in mandatory training.
- The care plans we reviewed covered the individual needs for the young people in the home. Staff could arrange external therapy if it would be helpful for the young person. Staff helped young people to build life skills to prepare them for discharge.
- Young people had access to a number of experienced staff with different professional backgrounds. They met weekly. We saw that staff were kind and respectful when speaking with young people. They clearly knew the needs of the young people living at the home. Young people were involved in staff meetings and said they felt listened too. In house chefs made meals to meet the needs of the young people.
- The provider responded quickly to the issues highlighted by this inspection and put measures in place to address them

However,

- Systems were not always either in place, or robust enough when it came to managing medicines safely, notifying the Care Quality Commission about safeguarding concerns, and ensuring audits were completed in staff absence. We raised these concerns with the provider and they acted quickly to address them. The provider introduced policies to address the shortfalls and trained their staff on the new procedures.

Summary of findings

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Good

Newcombe Lodge

Services we looked at
Child and adolescent mental health wards

Summary of this inspection

Background to Newcombe Lodge

Newcombe Lodge is an eight bed residential service for young women (between the ages of 13 and 21) that self-harm. Young people who require education are enrolled in a local education service run by the same provider as Newcombe Lodge.

They are registered to carry out the following regulated activities:

- Accommodation for persons who require nursing or personal care
- Treatment of disease, disorder or injury

The home has a registered manager.

The home was last inspected on 9 August 2013 and was found compliant with all of the outcomes inspected at that time.

Our inspection team

Team leader: Luke Allinson, inspector

The team that inspected the service comprised two CQC inspectors and a specialist pharmacist inspector.

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 the location.

During the inspection visit, the inspection team:

- visited the home, looked at the quality of the ward environment and observed how staff were caring for young people
- spoke with two young people
- spoke with the registered manager
- spoke with 6 other staff members; including a psychologist and therapy support workers
- attended and observed a hand-over meeting and a care review meeting
- looked at three care and treatment records of patients
- reviewed eight supervision records
- carried out a specific check of the medicines management at the home
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this inspection

What people who use the service say

Young people said that they felt listened to and involved in their care, they reported that staff were caring and considerate and mostly supportive.

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?

Requires improvement

We rated safe as requires improvement because:

- Medicines were not always managed safely. The provider did not have protocols for managing as required medicines; stock recording procedures meant that current stock and what the provider thought would be in stock did not match. There was an incomplete risk assessment for the one service user who was self-administering their medicine. The provider took steps to address these issues once we had highlighted them.
- The home did not always notify the Care Quality Commission when there had been allegations of abuse or when there had been safeguarding concerns raised. We raised this with the provider and they changed their policy.
- Mandatory training rates were low. Although the provider took some steps to mitigate this, it had not ensured that staff had the training required to allow safe care. For example only 70% of staff had received basic life support training.

However,

- The home had good furnishings and staff followed infection control procedures.
- Staffing levels had improved following a period of instability.

Are services effective?

Good

We rated effective as good because:

- The care records we reviewed had holistic and complete care plans for the young people. These plans included access to psychological therapies within and outside of the service. Young people also had independent living skills care planned for them.
- Young people had access to a number of experienced staff, and had access to a variety of professionals from different professional groups. For example, psychologists, psychotherapists, occupational therapy technicians and psychiatrists.
- Young people had access to weekly meetings with their care professionals.
- Staff reported good working relationships within the team, as well as with local services.

However,

Summary of this inspection

- Although the use of the Mental Health Act was rare and the home only took young people subject to a community care order (CTO). Staff were not clear on what restrictions might be in place for young people on a CTO.

Are services caring?

Good

We rated caring as good because:

- We saw that staff were kind and respectful when speaking with young people. They clearly knew the needs of the young people living at the home. The young people that we spoke with said that staff were caring, and mostly said they felt listened too.
- Young people were given chance to acclimatise to the home, and decide if it was a good placement for them. They were invited to staff meetings and were given the opportunity to feedback about the service in community meetings.

Are services responsive?

Good

We rated responsive as good because:

- Young people were admitted from around the country. Once they were admitted, they had a room kept for them when they were on leave. Young people were discharged at appropriate times for their needs, and were only moved due to changes in their clinical needs.
- The home had a good garden, and indoor facilities for young people to have activities and therapy. Young people were encouraged to decorate their room and to personalise it.
- Young people's dietary needs were met by the chefs that prepared the meals and staff could help young people access local religious services.
- Staff knew how to handle complaints, and staff and young people were kept informed about the outcome of investigations into complaints.

However,

- The home had some facilities for people with disabilities but the home would not accept referrals for young people who had mobility issues.

Are services well-led?

Good

We rated well-led as good because:

Summary of this inspection

- The manager of the home was involved in the day to day care offered there. Senior provider managers also visited the home and provided good leadership. Staff were aware of the provider senior managers and of the providers vision and values.
- Governance systems helped to manage changes in staffing levels and ensure that gaps in mandatory staff training were also mitigated.
- Staff reported that morale was improving following instability in the staffing levels and that they felt supported by managers through this time.
- The provider responded quickly to the issues highlighted by this inspection and put measures in place to address them.

However,

- There were no systems in place to ensure audits were completed when staff were absent.

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.

- The home only took young people who were on community treatment orders, young people who were not detained or young people who were under a Care Order. In the year prior to inspection, only one young person had been subject to a community treatment order. It was more common for children to be looked after children than for them to be detained under the act.
- The home could access advice from their provider should they need more information about how to apply the Act.
- Young people also could read their rights from a poster on a notice board in the entranceway of the home.
- Training in the Mental Health Act was included in the statutory training for mental capacity and only covered the parts of the act relating to consent to treatment. At the time of inspection, 73% of staff had completed this training. When we spoke with staff, they were unable to provide much detail on the rights of people who were detained under the Act or what being on a community treatment order meant. However, they said that they would raise any questions with the manager of the home (a registered mental health nurse) if they needed too.
- The clinic room and medicines audit contained checks for whether young people had the correct documentation regarding consent to treatment if they were detained under the Mental Health Act.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Only 73% of staff had received training on the Mental Capacity Act and deprivation of liberty safeguards.
- Staff told us that it was the responsibility of the senior team and the psychiatrist to decide whether a young person had capacity. However, they were aware that they should assume that a young person has capacity to refuse their medicine and described how they would encourage young people to take their prescribed medicine. There was a Mental Capacity Act policy for them to refer too and they could seek advice from their provider if they needed to. Staff were aware of Gillick Competency.
- The home reported that they had made one urgent deprivation of liberty safeguard application in the six months prior to inspection.

Good

Child and adolescent mental health wards

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

Are child and adolescent mental health wards safe?

Requires improvement

Safe and clean environment

- Newcombe Lodge was designed as a home. This meant that there were blind spots and staff could not observe all parts of the home from a specific point. Instead, staff used different levels of observation to manage the risk of the individual young people.
- We saw that there were some ligature points (a ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation) in the home. These included some door closures and some of the radiators in the home. We saw that the provider had recently conducted a ligature audit of the home and they provided us with an action plan to address these ligature risks that included specific action points as well as a time line for them to be addressed.
- The clinic room at the home was clean, and the home had an emergency response kit in the staff office. This kit included an automatic defibrillator. Staff had checked this regularly and demonstrated how they would do this. The therapy support workers and senior therapy support workers carried waist bags with ligature cutters in them.
- The home did not have a seclusion room.
- Overall the home was clean with good furnishings. We saw a few pieces of damage to the walls. However, Staff told us that when damage was caused to the furnishings, the provider organised quick repairs to the building. We saw that this had recently taken place.
- We saw that there were handwashing facilities, and posters that demonstrated recommended hand washing procedure. Staff also had access to sanitation gel in the clinic room.
- The manager of the home said that there was a personal alarm that staff could use if necessary in the home, or they could shout for help as the house was small. This was left to staff to decide on based on the young person's level of risk.

Safe staffing

- At the time of inspection, there was one registered nurse and 34 non-registered clinical staff (that included therapy support workers and senior therapy support workers). Staff told us that there were six vacancies for support workers at the time of inspection, and that interviews were due for the week after the inspection. The manager had covered 107 shifts over the three months before the inspection with bank or agency staff. There had not been any shifts that could not be covered by bank or agency. The sickness rate for the year prior to inspection was 6% and there had been 27 staff members leave (77%). Staff told us that this turnover rate was due to a change in provider and a closure of a local unit for renovations.
- The provider had a set staffing level based on the number of young people living in the home. During a shift, one member of staff had responsibility for two young people and would care for them. Extra staff were put on shift to manage identified patient needs. For example, if a young person was put on one-to-one

observations. Senior members of staff were considered outside of these numbers, and were available to provide extra clinical input if they were needed. We reviewed the staffing rota for the month prior to the inspection and saw that staffing met the levels that the provider had set.

- There was enough staff to ensure that young people had time to have one-to-one meetings with their named member of staff. We saw that this was documented in care records.
- We saw evidence that staffing levels were adjusted to allow for young people to attend activities off-site and staff told us that it was rare for activities to be cancelled.
- Staff could call a consultant psychiatrist between 9am and midnight, or could contact local emergency mental health services outside these hours. Young people were also registered with a local general practitioner for their physical health needs.
- Mandatory training rates were low. The only mandatory training rates where over 75% of staff had completed the training were in; protection of children (78% of staff had completed it), food hygiene (78%), equality and diversity (80%), medicine awareness (80%) information governance (80%) and medicine administration (85%). This was six out of a total of 16 different topics. The provider gave us an action plan for meeting their training needs and also we saw evidence that where there were gaps in training such as basic life support (which only 70% of staff had completed), they ensured that there were staff on shift that had been trained.

Assessing and managing risk to patients and staff

- In the six months before the inspection, the provider reported no incidents of seclusion or long term segregation, and one incident of restraint. The provider did not report any face down restraints.
- The management team at the home would screen referrals for risk, and would risk assess young people during the beginning of their stay. Risk assessments were mostly updated routinely and completed. We only saw one example (out of three care records) where an assessment for a young person to self-administer medicine had not been fully completed. We brought this to the attention of the manager and they arranged for the young person to be risk assessed fully.
- The home had some restrictions based on bladed items and pieces of glass. The service housed young people who self-harmed. Young people were not allowed to keep bladed items such as razors (which would be kept by staff in a safe when it was not in use) and were restricted in having items in line with national guidance.
- The house had key codes for the main door. However, young people had the code and could choose to leave when they wanted too. Staff we spoke with said that they recognised that young people were free to leave if they were not detained, but they encourage the young person to stay. The service had a missing person policy that would be used if a young person were discovered to be missing.
- Staff used observation in order to manage young people's risk of self-harm. The manager had negotiated with commissioners extra funding for one-to-one observation when a young person's risk was high.
- There were low incidents of physical restraint. Physical restraint can be described as any physical contact used to prevent, restrict, or stop movement of the body (or part of the body) of another person. The provider was in the process of changing the training provider (to be in line with other services the new provider owns). One member of staff had finished training to become a trainer at the time of inspection.
- The staff told us that they did not use rapid tranquilisation, and we saw no evidence that they had used it. Rapid tranquilisation is the use of medicine to calm/lightly sedate the patient, reduce the risk to self and/or others and achieve an optimal reduction in agitation and aggression.
- The GP or psychiatrist prescribed medicines for people who used the service. A community pharmacy in Stroud supplied the service with medicines and printed medicine administration records (MARs). The care workers completed the MARs and we could clearly see when people had taken their medicines. Staff double signed handwritten additions on the MARs and wrote notes when medicines were omitted. This was good practice.
- Some service users took medicines prescribed for as required use; these included medicines to manage mental health and physical health conditions. The service did not have as required treatment protocols in place. The therapy care workers (unregistered healthcare workers) administered medicines to the service users. This meant that they may be unaware of what common side effects of medicines may be, when to notify a medical professional or what the medicines

were used for. However, the care workers received training on the safe use of medicines and completed an assessment of competence before administering medicines to people. We brought this to the attention of the provider and they implemented changes to their policy to address this.

- While medicines were stored securely and at the correct temperatures, the stock recording system did not accurately record the quantity of medicines held by the service. This meant that it was difficult for staff to identify if medicines went missing or if service users had not received their medicines as prescribed. The cupboard contained some medicines that were not documented on service users' MARs. If the medicines were not needed then the service should dispose of them, if the medicines were needed then they should be prescribed on the service user's MARs to allow for safe administration. The community pharmacy took away medicines that were no longer needed. The staff did not always follow the process for recording medicines for destruction.
- The healthcare team assessed one service user as appropriate to self-administer some of their medicines. Although a risk assessment had been carried out, staff had not completed all of the details. For example, the service user had not signed the competency statement and the psychiatrist had not signed the document. The medicine policy did not detail the process to follow to risk assess someone for self-administration or the responsibilities for assuring self-administration was being conducted safely.
- There was a policy for visitors to the home, and young people could see visitors in one of the two lounges downstairs, or in the dining room. Visitors were not allowed upstairs in the home where the young people had their bedrooms.

Track record on safety

- The home reported seven serious incidents between May 2015 and May 2016. The majority of the incidents were of young people leaving the home without telling staff for longer than 12 hours, and the next most common was of attempted ligature. The service had discussed learning from these incidents at team meetings and had put some measures in place to address gaps in their management of the incident. These measures included making a 'intelligence pack' on service users when they started at the home so that this could be provided to the police should they go missing, and looking at ending a young person's placement earlier if they were of high risk of tying a ligature. When a young person's placement was ended, the commissioners arranging their care would find a more suitable placement for the young person at a different care provider.

Reporting incidents and learning from when things go wrong

- Staff knew how to report an incident internally. However, we saw that they did not always notify us when an allegation of abuse or safeguarding concern had been raised. We had received three safeguarding notifications before the inspection since January 2016, but when we checked their records, we saw they had logged eight allegations of abuse or safeguarding concerns. We had previously signposted the service to our guidance on making notifications a year prior to the inspection. When we raised this on inspection, the provider immediately submitted notifications to the Care Quality Commission, backdating the incidents they had not notified us of.
- Staff were open and transparent with young people when things had gone wrong. We saw staff discussing incidents with young people during a review meeting.
- Learning from incidents was discussed at weekly meetings, as well as in individual supervision. Staff reported being able to seek support from senior members of the team. The service also had a clinical psychologist who would provide extra debriefing to staff following an incident.
- We saw that staff had implemented some learning from serious incidents. However, we noticed from the statutory notifications that the provider submitted to us that some young people had left the service (without telling staff) multiple times and that one young person had engaged in the same type of self-harm on three occasions, despite staff re-assessing the patients risk and deciding not to remove the opportunity for this to happen.

Are child and adolescent mental health wards effective?

(for example, treatment is effective)

Good

Child and adolescent mental health wards

Good

Assessment of needs and planning of care

- We reviewed three care records. We found that the care plans were of good quality and addressed young people's needs. We saw plans covering a variety of different aspects, including how they wish the staff to manage their self-injury behaviour, and how they would meet their educational needs. We saw evidence of assessments for independent living skills and care plans to help young people live successfully in the community.
- We saw evidence that young people were receiving physical health checks. Staff reported that all young people at the home were registered at a local general practitioner.
- The service was currently using a mixture of paper and electronic records (different parts were stored in different systems). However, the service was moving to electronic records shortly after the inspection. We saw that this did not impact on care during the transition.

Best practice in treatment and care

- The provider distributed updates to national guidelines from the national institute for health and care excellence (NICE) to the manager who printed them off and displayed them.
- The service had a clinical psychologist and a psychotherapist that could provide psychological therapies recommended by NICE. For example, cognitive behavioural therapy and dialectical behavioural therapy. These therapists provided allocated sessions for young people. Staff also told us that young people sometimes had therapies commissioned for them outside of the service. For example, equine therapy and we saw evidence that this was arranged.
- Clinical staff used a number of different recognised rating scales (to measure the clinical progress of a young person). For example, the health of the nation outcome scales child and adolescent mental health and the model of human occupation screening tool.
- We saw evidence that the service manager conducted weekly audits of the medicines charts and of the clinic room. However, we saw that there were not cover arrangements for when the manager was on leave and so the audits were not completed at those times. This meant that issues that would be highlighted by the audit may get missed should the manager be on leave or sick.

Skilled staff to deliver care

- The clinical staff were, in the large majority, not professionally qualified. However, young people had access to a clinical psychologist, psychotherapist, a psychiatrist, an occupational therapy technician and the manager of the home was a registered mental health and general nurse.
- There had been relatively high staff turnover in the year before the inspection. However, we spoke with staff who had been working at the home for number of years who provided a sense of stability and experience in the home.
- After new staff had completed their three month probationary period, they could complete a qualifications and credits framework diploma level three in health and social care.
- The majority of the clinical staff attended weekly meetings. Staff had supervision from members of staff monthly. The members of staff with professional qualifications received supervision from external sources. We reviewed eight supervision records and found that in the majority staff were receiving supervision in line with the policy. However, staff had difficulty finding documentation for individual supervision for staff members whose supervisor was off work.
- All of the non-medical staff had received an appraisal in the year before the inspection.
- Staff reported some access to specialist training. One member of staff had received support from the provider to attend a master's degree in art therapy. We spoke to staff that had applied for training and were awaiting a response from the provider.
- Staff told us there were no current cases of performance management at the time of inspection. However, staff were aware of the policy surrounding performance management.

Multi-disciplinary and inter-agency team work

- Young people had weekly review meetings. A therapy support worker attended, and the occupational therapy technician and the young person's therapist were invited to attend. Staff told us that young people met

with the home's psychiatrist when needed and that multidisciplinary team meetings only truly occurred when there was a risk management meeting for a young person.
- Staff had half an hour handover between shifts. They discussed the progress notes from the previous shift and allocated tasks that needed to be done, i.e. picking up the young people from school.
- Staff reported good relationships with local safeguarding teams, the police and national commissioners. Prior to the inspection, we had received concerns from local bodies about how the service liaised with them. However, the service had engaged with them to improve the relationship.

Adherence to the MHA and the MHA Code of Practice

See the Mental Health Act section above.

Good practice in applying the MCA

See Mental Capacity Act section above.

Are child and adolescent mental health wards caring?

Good

Kindness, dignity, respect and support

- The young people that we spoke with said that staff were kind and caring. They mostly said that staff listened to them and helped them to meet their needs.
- We observed staff in meetings with young people, and with other staff members. We saw that they spoke with respect about young people, both between themselves, and when meeting with young people. Staff clearly demonstrated that they cared for the wellbeing of the young people. Staff demonstrated understanding of each young person's likes and dislikes, as well as their care needs.

The involvement of people in the care they receive

- When young people were being admitted to the home, they were able to have multiple day visits, as well as day visits to the school they could attend. Young people were also enabled to have overnight stays at the home to help them feel at home and see if it was suitable for them before they moved in.
- We saw clear evidence that young people were involved in designing their care plans, and had a chance to give their wishes on how staff should treat them when they were at risk of self-harming. Young people that we spoke with said they felt involved in their care.
- Young people were encouraged to maintain independence and the home had a separate area with two bedrooms and their own kitchen. These beds were used for young people who were ready to transition out into the community and young people received input from an occupational therapy technician to help develop key life skills.
- The notice board in the entrance hall gave contact details for a named advocate for young people. Although the young people we spoke with had not used advocacy, they were aware of how to access it, if they needed it.
- Young people had daily community meetings with staff so they could pass on any concerns and decide what activities they wanted to do that day. The home also had monthly business meetings with their management team and young people and had started to involve young people for part of the weekly staff meeting.
- There were feedback forms and a suggestion box in the entrance hall, and the manager said they had an open door policy for young people to give feedback. The young people we spoke with said that the service also involved their family appropriately.
- Staff told us that young people had been involved in recruiting new therapy support workers.

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

Good

Access and discharge

- The home took young people from around the country as they are a specialist service for young women who self-injure. In the six months prior to the inspection, the average bed occupancy was seven out of eight beds.
- Young people often had home visits (where appropriate) and at the time of inspection, one young person was on a family holiday. Their rooms were kept for their return.

- If a young person became too unwell or their risk level increased then the home would put in place one-to-one observation levels. If the level of risk was too high for the home to manage, or the young person became so unwell that they required acute inpatient mental health care, then staff would find another placement for young people.
- Staff told us that when young people were discharged or moved to another placement, this would happen at an appropriate time of day for the young person's needs. The service would try to ensure it happened on a week day for a planned move or discharge so that they could hold a leaving party and give the young person chance to say good bye to staff and the other young people.
- There had been three delayed discharges in the three months prior to the inspection. The home recorded these when they had issued notice to end a young person's placement and the young person's commissioning team had been unable to find another placement, meaning that the young person stayed with the home until another placement was found.

The facilities promote recovery, comfort, dignity and confidentiality

- The home had good facilities for young people to spend time in, including a craft room, two lounges and a garden. The home also had two therapy rooms for the young people to have one-to-one therapy in.
- Visitors were welcome to have private visits in one of the lounges, or could visit their relative or loved one in the dining room of the home. Visitors were not allowed upstairs where the young people had their bedrooms.
- Young people could have their own mobile phones, or use the office cordless phone in order to have a telephone call in private. The home also had a computer and wireless access should a young person wish to use internet based methods of contacting people.
- The home had two chefs who would provide meals during the day, and they had access to hot drinks and snacks 24/7 as staff could access the kitchen. Young people could use the kitchen facilities, as long as the sharp implements were secured, or they were observed. Young people living in the separate living space had their own kitchen and had been risk assessed to have sharp kitchen implements. Both of the young people we spoke with said that the food was of good quality.
- Young people were allowed to decorate their room. The home also had young people involved in decorating the bathrooms at the home. We saw that young people had decorated their rooms to make them theirs, including posters, examples of their creative writing and artwork. One young person had pet fish. Staff said that contracts were drawn up with young people who wished pets, and if the pets were small and appropriate (fish for example) then the staff would help young people get the pet.
- Young people could securely store items in the staff office and could ask staff to fetch their belongings from that secure storage.
- There was mixed access to activities. Young people could decide which activities they wanted to do that day by attending the daily community meeting. We also saw that staff had accommodated for day trips and home visits in the staffing rota. Young people also had planned education sessions as appropriate. However, we reviewed records of eight daily planning meeting notes and saw that not all young people attended these meetings (there were three or less young people on five of these days) and we saw that young people often said they would 'maybe [do] something later'. One young person said that it was often boring at the home but they did have activities such as bowling, going to the cinema and going shopping.

Meeting the needs of all people who use the service

- The home did not have ramps for disabled access and the bedrooms were all upstairs and there was no lift. However, staff at the home told us they could assist visitors to access the home via the patio doors (which had a small step). There was a spacious bathroom downstairs with adaptations for people with disabilities and staff said that if a young person's mobility needs changed during their placement then they would assess the person's needs and provide aids where able. They could adapt one of the downstairs lounges into a bedroom if needed. The home did not take referrals for young people that could not walk unaided or climb the stairs in the home but they would try to signpost to other services.
- The entrance way had leaflets on a variety of subjects. Staff said that they could access information in other languages and easy read if they needed it. The notice board had information for young people about their rights, how to access advocacy and there were posters with contact details for ChildLine throughout the home.

Good

Child and adolescent mental health wards

- Interpreters could be accessed via local social services.
- Young people's dietary needs could be met by the in-house chefs.
- Young people who wished spiritual support would be supported to attend local religious services.

Listening to and learning from concerns and complaints

- There had been 17 complaints in the year before the inspection, eight were upheld, eight were not upheld and one was being investigated at the time of the inspection. Twelve of those complaints related to staff behaviour or staff neglecting their duties. Five of those 12 were from other members of staff. The service had responded to these by investigation, taking disciplinary action where necessary and through staff supervision.
- The young people that we spoke with were aware of how to raise concerns and said they felt comfortable with raising concerns with the manager of the home. One young person said they had made a complaint and it had been handled well by the staff.
- Staff that we spoke with knew how they should handle complaints, and said they would raise them with the shift leader and their manager.
- Staff received feedback in the outcome of investigations into complaints as appropriate. Staff discussed learning from complaints in the community meetings, as well as in business meetings. This ensured that young people were kept aware as well as staff.

Are child and adolescent mental health wards well-led?

Good

Vision and values

- Newcombe Lodge had been taken over by Partnerships in Care (PiC) a year before the inspection. However, staff said the new values and visions were similar to the ones of the previous provider. Staff were aware of the values and visions. The values were included in staff appraisals.
- All staff at the home were aware of the managers in the wider organisation structure. Staff were aware of these provider senior managers.

Good governance

- Governance procedures did not always ensure policies were regularly reviewed. The PiC policy on managing self-injury had not been reviewed or ratified since it had taken over the home. However, it reflected current guidance. The home manager said that a working group had been set up by the new provider to review and ratify the provider's policies to ensure they were appropriate for the provider's children and adolescent services.
- Staff turnover had been high, with the peak turnover being around December 2015 and January 2016. Despite there being roughly six months since the provider had reviewed the workforce, training rates were below the provider's target of 95% of staff having completed each of the statutory and mandatory training. The provider had booked extra training for staff following our inspection to help address the gaps in their training and had taken steps in managing their rota to ensure that there were some staff on shift who had basic life support training.
- Despite high staff turnover, systems were in place to ensure that staffing on each shift met the established levels. This included use of appropriate agency and bank staff.
- There were no procedures in place to ensure that medicines audits were conducted when the home manager was on annual leave or sick. Arrangements to cover staff supervision when there was staff sickness were not fully in place. Staff had difficulty in finding evidence it had taken place when a supervisor was off work. However, staff did have access to weekly meetings with other members of staff that they could use for supervision, and could ask senior staff for informal supervision if they needed it.
- There were systems in place to ensure that complaints and reported incidents were investigated and learning obtained from them.
- Following our inspection on the 23 June, the home changed their policy on notifying the appropriate external bodies of safeguarding alerts to ensure they were also notifying the Care Quality Commission. They already had robust systems for notifying local safeguarding authorities.
- The ward used a ward quality report to track performance targets. These targets included making sure care plans involved young people, vacancy rates and that complaints were tracked. These reports were issued quarterly and required the home to rate their performance as red, amber or green and provide a

description of how they were meeting the target. The home was due to move to electronic care records in October 2016, this would give them access to a quality dashboard.
- The home manager had the authority to carry out their role and reported they had good administrative support.
- The home had a local risk register, and would discuss this with the provider at monthly governance meetings. If the risk on the local register was significant, then it would also be placed on the provider risk register.

Leadership, morale and staff engagement

- The home manager was available to staff and was involved in the day to day care at the home. They provided good leadership at a local level and the providers' senior managers provided support and strong leadership to the home.
- Staff told us that there was a current case of staff bullying that was being managed informally in supervision. We saw that there had been complaints made by staff about the attitude of other staff. Staff were aware of the providers policy on staff bullying and all of the staff we spoke with said that they felt the team now communicated well with each other.
- Staff we spoke with were aware of how to whistle blow and said they felt comfortable raising any concerns that they had with senior management.
- Staff reported that the home was calm at the time of the inspection and that morale was now ok following an unsettled period when the service changed provider.
- The management team within the home had mostly been with the service for many years, having once been therapy support workers. Staff reported that there was training relevant for managers available from the provider.
- The manager of the home reported that they were involved in provider wide groups that gave them input on the development of their service.

Commitment to quality improvement and innovation

- The service was not currently involved in any research programs or national quality assurance programs.
- During this inspection we raised the issues we had found with the manager and the provider. They responded by implementing rapid action plans and weekly visits from the providers compliance lead until the service has resolved those issues.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

- The provider must ensure safe management of medicines in line with national guidance.

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

- The provider should ensure that they continue with the plan for statutory and mandatory training to be fully completed.
- The provider should ensure that measures are in place to ensure audits are completed when staff are absent.
- The provider should make all reasonable adjustments to ensure people who have limited mobility can access the service appropriately and should review how it manages referrals for people with mobility issues.

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
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment • The service did not have as required medicines treatment protocols in place. • The medicines stock recording system did not accurately record the quantity of medicines held by the service. • The medicine cupboard contained some medicines that were not documented on service users' medicines charts. • The staff did not always follow the process for recording medicines for destruction. • The medicine policy did not detail the process to follow to risk assess someone for self-administration or the responsibilities for assuring self-administration was being conducted safely. This was a breach of regulation 12 (1) (2) (g)