Good

Cheshire and Wirral Partnership NHS Foundation Trust

Child and adolescent mental health wards

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RXAPL	Pine Lodge	Pine Lodge	CH2 1AW
RXA19	Bowmere Hospital	Maple Ward	CH2 1BQ

This report describes our judgement of the quality of care provided within this core service by Cheshire and Wirral Partnership NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Cheshire and Wirral Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of Cheshire and Wirral Partnership NHS Foundation Trust.

Summary of findings

Ratings

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

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

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

The child and adolescent mental health wards had a good track record of safety. Staff were aware of the process of reporting and acting upon incidents. There was a clear understanding of the safeguarding process within the team. Staff took a proactive approach to safeguarding and this was explored with patients early into their hospital admission. Effective work took place with the local authority in relation to child protection and safeguarding concerns.

Staffing levels have been reviewed by the trust and increased to reflect the needs of the service. Thorough handovers took place with the multidisciplinary team to ensure relevant information was shared to support patients effectively.

The environment was clean, welcoming, and young person friendly. Patients were fully involved in the décor of the wards with their art work on display.

Patients' care and treatment was planned and delivered in line with best practice as recommended by National Institute for Health and Care Excellence. A number of psychological therapies were offered as well as family therapy. Patients were fully involved in their care. Young person friendly documentation was in use including "my anxiety plan". Comprehensive assessments were completed which included "my moving on plan" to focus on the future and discharge.

Patients completed self assessments upon admission and reviewed these during their stay.

The service was involved with the Quality Network for Inpatient CAMHS, which accredited them as excellent. Internal peer review took place with other wards.

Feedback from patients, their parents and carers was excellent about the care they received.

We observed young people were treated with dignity and respect. Staff interactions with patients were positive, nurturing and encouraging. Staff genuinely cared about the patients and respond appropriately to their needs.

Information about medication and treatment was freely available in a format that was meaningful to young people.

Education was an important and embedded part of the service. The education sessions were tailored to the needs of the patients. Ofsted rated the education provision as outstanding.

The trust had a clear vision and values which the staff and patients were aware of. Information from the executive board was disseminated to the staff team via team meetings. Regular email updates were used for all staff.

The ward managers were approachable. Staff reported, and we saw, an open door policy. Staff were confident at seeking guidance from the ward managers.

Regular supervision took place both individually and group supervision.

Summary of findings

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

Are services safe?

Good

We rated safe as good because:

- There was a good track record of safety. Staff were aware of the process of reporting and acting upon incidents. There was a clear understanding of the safeguarding process within the team. Staff took a proactive approach to safeguarding which was explored with patients early into their hospital admission. Effective work took place with the local authority in relation to child protection and safeguarding concerns.
- As a result of a staffing review staff levels have increased. The multidisciplinary team had thorough handovers to ensure relevant information was shared to support patients effectively. Presentation of patients was reviewed on a daily basis. Changes in need were included in the detailed risk assessments that were in place.
- The environment was clean, welcoming and young person friendly. There had been a new seclusion room built on Maple ward following feedback from Mental Health Act reviewer visits regarding the previous room. However it was not in use at the time of the inspection.

However:

- Staff attend mandatory training but they had not achieved the expected level set by the trust of 85%.

Are services effective?

Good

We rated effective as good because:

- Patients' care and treatment was planned and delivered in line with best practice. A number of psychological therapies were offered as well as family therapy. Patients were fully involved in their care. Young person friendly documentation was in use including my anxiety plan. Comprehensive assessments were completed which included my moving on plan to focus on the future and discharge.
- Outcomes were collected and monitored, the service was involved with and accredited by the Quality Network for Inpatient CAMHS as excellent. Internal peer review takes place with other wards.
- There was a good understanding of the Mental Health Act and the responsibilities in relation to this, information was displayed in communal areas for patients.

Summary of findings

- Staff were skilled and motivated, there was excellent multi-disciplinary working with access to tailored training and group supervision in addition to individual supervision. The majority of the team had received an appraisal within the last 12 months.
- Admission to Pine Lodge was planned, if there was a transition from Maple Ward to Pine Lodge the information moved with the individual to ensure consistency of care. All staff were competent at accessing the electronic systems and could access information in a timely manner.

However:

- Although staff attended training in the Mental Capacity Act there was limited understanding of how the Act applied to their client group.

Are services caring?

Good

We rated caring as good because:

- At admission patients were provided with a welcome pack and orientated in the ward environment. Information was accessible prior to admission via the mymind website with additional information and resources relating to mental health and wellbeing.
- Feedback from patients, their parents and carers was excellent about the care they receive. People were treated with dignity and respect, staff interactions with patients were positive, nurturing and encouraging.
- Patients were involved in their care. They all knew who their named nurse was and spend time with them. Patients reported being listened to, they were aware of the advocacy service and had made use of it. They felt comfortable raising issues within the community meetings.
- Staff genuinely cared about the patients and responded appropriately to their needs. Information about medication and treatment was freely available in a format that was meaningful to young people. Staff responded compassionately and sensitively when patients were distressed, advocating on behalf of young people to maintain their privacy and dignity.
- The majority of families reported being included in their child's care and reassured and informed when questions were asked.

Are services responsive to people's needs?

Good

We rated responsive as good because:

Summary of findings

- The activities and environment were steered by the patients. They were fully involved in the planning and information displayed in the environment including their artwork. The information displayed was meaningful and accessible to young people.
- The transition from Maple Ward to Pine Lodge was smooth, there was clear and positive communication with both ward managers and some staff have worked in both environments.
- Education was an important and embedded part of the service. The education sessions were tailored to the needs of the patients, and the education provision had been rated as outstanding by Ofsted.
- Complaints were welcomed. Information was on display of how to complain. Evidence showed patients being supported to complain. The outcome of the complaint was communicated to the patient in writing or verbally, the learning was shared via community meetings and staff team meetings.
- The services' bed occupancy was below the trusts' target which allowed for timely admission to the service. Pine Lodge had four beds as part of the Cheshire and Merseyside adolescent eating disorder service, focusing on the best practice with this group of young people.
- Pine Lodge had access to cold drinks in a communal area which young people could access any time. However at Maple ward young people could only access cold drinks if they were assessed as being able to manage a fob to gain access into the dining room as their cold drink provision was in the locked dining room.

Are services well-led?

Good

We rated well-led as good because:

- There was a clear vision and values which the staff and patients were aware of. Information from the board was disseminated to the staff team via team meetings. Regular email updates were used for all staff.
- Databases and records were in place to monitor training, supervision, appraisal rates, sickness and recruitment and selection. There were monthly training sessions tailored for the team. There was administrative support in both settings and we observed positive interactions and knowledge of location of information and data.
- The ward managers were approachable. Staff reported and we saw an open door policy. Staff were confident at seeking guidance from the ward managers. Staff reported receiving praise from senior managers both verbally and by email.

Summary of findings

- Staff receive supervision every four to six weeks, group supervision was available monthly facilitated by a family therapist.
- Staff at all levels were knowledgeable about patients as individuals and their individual preferences.
- Feedback was welcomed. The focus was on improving quality, and Maple Ward had been accredited with the Quality Network for Inpatient CAMHS as excellent.

Summary of findings

Information about the service

Child and adolescent mental health (CAMHS) Tier 4 children's services deliver specialist in-patient and day-patient care to children who have severe and/or complex mental health conditions that cannot be adequately treated by community CAMHS.

The CAMHS Tier 4 inpatient services provided by Cheshire and Wirral Partnership NHS Foundation trust are in two settings;

- Maple Ward is a 12 bed acute admission ward for young people aged between 13 and 18 who require emergency admission due to their mental health needs. All of the bedrooms are en suite and there is a dining room and a lounge area. There is education provided on site. Ten beds are contracted by North West Specialised Commissioning Team on behalf of Cheshire and Merseyside commissioners. An additional two beds are available on a spot purchase basis
- Pine Lodge is a 14 bed planned admission unit for young people aged between 13 and 18 who need therapeutic intervention. Four of the beds are for young people with an eating disorder. The bedrooms are not en suite at Pine Lodge. There was a female and male bathroom. Education is provided on site. Young people can move to Pine Lodge from a stay at Maple ward or can access Pine Lodge directly.

Our inspection team

Our inspection team was led by:

Chair: Bruce Calderwood, Director of Mental Health, Department of Health (retired)

Head of Inspection: Nicholas Smith, Care Quality Commission

Team Leaders: Sharon Marston, Inspection Manager (mental health), Care Quality Commission,

Simon Regan, Inspection Manager (community health services), Care Quality Commission

The team comprised: two CQC inspectors, a consultant psychiatrist specialising in child and adolescent mental health services (CAMHS), a consultant psychologist, two mental health nurses specialising in CAMHS, an expert by experience with lived mental health experience, an expert by experience whose child accesses services.

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

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

We visited Pine Lodge and Maple Ward on 23 June 2015. During the inspection visit, the inspection team:

- toured both environments

Summary of findings

- met with ten young people who were patients on the wards
- received 16 completed comment cards
- spoke with 12 staff
- spoke with two parents and carers
- observed an education session at Pine Lodge
- observed a community meeting at Pine Lodge
- observed a multi-disciplinary meeting to give a handover of events in the previous 24 hours at Pine Lodge
- Observed a multi-disciplinary meeting to discuss a young person who was a patient on Maple Ward
- reviewed eight prescription charts
- reviewed 12 care records
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We spoke to ten patients. Feedback from patients was that staff were easy to talk to and were welcoming and positive.

The education sessions provided were well received, especially the opportunity to walk the dog.

Patients report using the advocacy service, they would also use this service to raise concerns.

On admission patients had a tour of the building and their support needs were discussed.

Patients reported that the environments were calming.

Parents we spoke to said the staff really listen, they felt the staff encourage their children to be involved in activities that promote their independence including using the washing machine and cooking. Parents felt the young people's mental health needs had improved from the support provided by both services.

Comment cards were generally positive, with 11 out of 16 reporting the staff were respectful, supportive, helpful and caring.

The area for improvement from four of the comments cards was that communication could be improved; family members did not feel included in the care of their loved ones at Pine Lodge.

Good practice

The education provision at both Maple ward and Pine Lodge has been rated by Ofsted as outstanding. We observed individually tailored education during inspection.

Areas for improvement

Action the provider SHOULD take to improve

- The trust should ensure that all staff attend mandatory training. Particular focus should be on the management of violence and aggression and the alternative courses for those staff excluded from the training.
- The trust should complete the outstanding work on the seclusion room on Maple ward to ensure that the room is fit for purpose and seclusion facilities are available on the ward if a patient requires seclusion.
- The trust should ensure that staff understand their role and responsibilities in relation to the Mental Capacity Act. Although staff had attended the training they had limited understanding of the age that the act applies from and the implications for the patients they were caring for.

Summary of findings

- The trust should enable patients to access hot and cold drinks on Maple ward even if they are assessed as not being able to manage a fob to gain access into the dining room.

Cheshire and Wirral Partnership NHS Foundation Trust

Child and adolescent mental health wards

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Pine Lodge	Pine Lodge
Maple Ward	Bowmere Hospital

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.

Training in the Mental Health Act (MHA) was mandatory, renewable every three years. The trust target is 85% attendance, data provided by the trust showed 84% compliance with the training which is below their target.

At the last Mental Health Act reviewer visit at Pine Lodge on 22 January 2015, they were providing care and treatment in line with the MHA code of practice.

The Mental Health Act reviewer visit at Maple Ward on 8 April 2015 highlighted that there was inconsistency around recording that the responsible clinician had made an assessment of capacity to consent to treatment and whether or not the patient was consenting. During the inspection the care records that were reviewed had the capacity to consent to treatment recorded in the daily notes however this was quite difficult for the inspection team to find.

Mental Capacity Act and Deprivation of Liberty Safeguards

The Mental Capacity Act (MCA) does not apply to young people aged under 16. For children under the age of 16, the young persons' decision making ability is governed by Gillick competence. The concept of Gillick competence recognises that some children may have a sufficient level of maturity to make some decisions themselves. When

working with children, staff should assess whether or not a child has a sufficient level of understanding to make decisions. The Mental Capacity Act does apply to young people aged 16 and 17.

Staff that were asked about the MCA advised of the policies available in the office and information on the trust intranet. However there was limited understanding of the Mental Capacity Act by staff and how it would relate to the patients that they were caring for. For example a staff member did not know at what age the Act applies from. All staff asked could not explain the five statutory principles of the MCA.

The training for Mental Capacity Act was renewable every 3 years. The trust target was that 85% had attended the training within the timescales. From the data provided by the trust 82% of the staff had attended the training within the timescales which is below their target.

Good

Are services safe?

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

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Summary of findings

Our findings

Safe and clean environment

Young people led members of the inspection team round for a tour of the environment.

Both Pine Lodge and Maple Ward had several blind spots. Pine Lodge was on several levels with no clear line of sight. The trust had a suicide prevention environmental assessment report dated July 2014 in place. Ligature points were noted and a ligature management plan was in place, dated June 2015. Photographs were in use in the ligature management plan to ensure increased accessibility. Due to the limitations of the environment at Pine Lodge staff reduced the risks to patients by increasing their supervision of patients. A weekly safety audit also took place to highlight any risks that needed addressing.

The clinic rooms had resuscitation equipment in place and records showed that staff had made daily checks of the equipment. The fridge temperature was within the recommended levels and there was a record in place to show checks of fridge temperature.

Pine Lodge had a recently created low stimulus room, with relaxing lighting and music to provide a quiet place for patients.

Both Pine Lodge and Maple were welcoming, clean environments, with patients' art work on the walls. The furniture was good quality and sturdy. There was information in leaflet racks about medication and mental health needs tailored for young people with plain English and graphics.

Staff adhered to infection control principles, with very limited jewellery and were bare below the elbows in the ward environment.

There was a seclusion room on Maple Ward, which was not in use at the time of inspection as they were waiting for a mattress to be delivered and had plans to fit a clock. There was a step down room that could be used if a patient needed a quieter environment with low stimulus. If a patient needed secluding staff had to use facilities on another ward. We were told that this happened on two occasions in the last six months. The patients were nursed by CAMHS staff on the extra care facility of an adult ward due to a lack of seclusion facility on Maple ward. Maple ward did not have any seclusion records available to review at the time of inspection.

Staff used personal alarms and offered to the inspection team too.

Safe staffing

The figures below were provided by the trust and relate to the time period 01/01/2015 – 31/03/2015.

Establishment levels: qualified nurses (WTE) 28, nursing assistants (WTE) 30.

Number of vacancies: qualified nurses, whole time equivalent (WTE) 1.9 (7%), nursing assistants (WTE) 4.2 (14%).

The number of shifts filled by bank or agency staff to cover sickness, absence or vacancies in the three month period were 111 at Maple Ward and 181 at Pine Lodge.

The number of shifts that had not been filled by bank or agency staff where there was sickness, absence or vacancies in the three month period were 40 at Maple Ward and 74 at Pine Lodge.

Staff sickness rates in 12 month period was 2.3% at Maple Ward and 7% at Pine Lodge.

Staff turnover rate in 12 month period was 2.5% at Maple Ward and 10% at Pine Lodge.

There was a staffing review and staff told us that because of this there have been more staff allocated to the service.

Maple ward mainly used bank and agency staff to facilitate the increased observations of young people. A young person confirmed that when they had been a patient at Maple ward previously, there was bank and agency staff usage which had an impact on activities and leave. However on this admission they had not had any bank or agency staff and the activities and leave had not been affected.

Good

Are services safe?

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

At the time of inspection young people were participating in education, sports activities and beauty sessions in preparation for a ball. They were all supported on a one to one basis. Patients reported that staff were available to talk to .

At Pine Lodge two young people said at times there are not enough staff to offer the levels of observation required or have an instant response from a staff member if they are experiencing heightened emotion. We did not observe this on the day that we visited.

The trust had a number of mandatory training courses including; equality and diversity, health and safety, moving and handling, and management of violence and aggression. Information provided by the trust prior to the inspection showed that overall the staff in inpatient CAMHS services had achieved 81% of their mandatory training, which is slightly below the trust target of 85%. Management of violence(MVA) and aggression training had achieved 47% but updated figures received from the trust on 26 June 2015 show 73% attendance of MVA. Managers told us that 16 staff were exempt from attending the MVA training due to their health needs and occupational health had been involved in this decision. The staff could not perform any of the physical interventions and were offered alternative training of breakaway and basic life support. This date also showed that 73% of staff had attended basic life support training within the refresher timescales.

Assessing and managing risk to patients and staff

Data provided by the trust from Oct 2014 to March 2015 showed the number of incidents of use of seclusion as two at Maple Ward and none at Pine Lodge. Number of incidents of use of long-term segregation in the last six months was none.

Number of incidents of use of restraint in the last six months was 41 at Maple Ward and none at Pine Lodge. Of those incidents of restraint, the number of incidents that were in the prone position was 30.

We reviewed 12 care records. Seven of them had detailed and comprehensive risk assessments in place. Four of the risk assessments only covered risk to self and others but did not explore any other areas of risk. We could not find a completed risk assessment in one of the records. The recognised risk assessment tool used was clinical assessment of risks to self and others.

There were no blanket restrictions. Blanket restrictions are rules or policies that restrict a patient's liberty and other rights which are routinely applied to all patients or within a service, without individual risk assessments that we were aware of in either of the wards.

We observed positive interactions with patients who were distressed and staff used de-escalation techniques. Patients confirmed that de-escalation was used and only if this is not successful do staff then restrain.

Safeguarding Family level one and level two training had been completed by 90% of the staff team. Staff we spoke to were aware of how to make a safeguarding alert and were aware of the safeguarding team within the trust. Staff told us they had the opportunity to attend safeguarding drop ins with the lead nurses and found the safeguarding team helpful and knowledgeable.

We reviewed eight prescription charts, six of the patents prn medication, which was prescribed when needed, had not been reviewed for more than 14 days.

Track record on safety

There had been no serious incidents in the last 12 months.

Within the community meeting minutes we reviewed, there were discussions on risk and patients had made suggestions.

Reporting incidents and learning from when things go wrong

There was a clear six stage step of action in how to respond to an incident which included datix, the electronic incident reporting system used by the trust, recording and reporting to managers.

Staff reported that immediately after an incident they were offered a debrief and the incident was discussed in individual supervision. Patients were also offered a debrief following an incident.

Are services effective?

Good

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

Summary of findings

Our findings

Assessment of needs and planning of care

We reviewed 12 care records. All of the care records had comprehensive care plans in place, patients were involved in the creation of the care plans. Patient centred documentation was in place including 'my coping skills plan' and 'my anxiety plan'. They included triggers, warning signs, what helps me calm down and how to support me. We saw two plans that were completed by the patients. Care plans were recovery focused, including 'me moving on' sections and a contingency plan.

Seven of the care records had timely physical health examinations completed on the day of admission. Two care records had physical health examinations in place. However these were completed a few days after admission or were not completed fully. Three of the care records did not have a physical health examination in place. Nine of the 12 records showed evidence of ongoing physical care and checks.

All staff were competent at using the carenotes system and could locate relevant information. Patients had moved between Maple ward and Pine lodge and their electronic notes were accessible from the previous ward to ensure continuity of care.

Best practice in treatment and care

The eight prescription charts that were reviewed followed NICE guidance in relation to prescribing medication. Staff were aware of the NICE guidance and reported the availability of the guidance within the workplace and the expectation to read it to remain informed.

The headspace toolkit was in use which was created by advocacy in Somerset. It covered rights, reasons for being in hospital, making decisions about their care and 'power tools' which are guidance sheets and prompts for young people to express themselves and communicate more effectively during a hospital admission.

The patients could access family therapy, occupational therapy, dialectical behaviour therapy(DBT) and cognitive analytic therapy. Patients accessed individual therapy sessions or group sessions including the coping skills group. Outcomes were measured by the completion of the difficulty in emotion regulation scale, DBT ways of coping checklist and mood and feelings questionnaire. Health of the nation outcomes scales were used and linked to the care plan.

Maple Ward had been accredited with the Quality Network for Inpatient CAMHS as excellent in March 2014. The achievements included "the policies and procedures used by the unit are robust, reviewed regularly and implemented well" and "the unit has good systems in place for gathering outcome data and using this information to inform service development and staff supervision"

Skilled staff to deliver care

The multi-disciplinary teams at Pine Lodge and Maple ward include consultant psychiatrists, nurse practitioner, occupational therapist, technical instructors, psychologist, family therapist, nurses, support workers, a participation worker and a resource manager.

In addition to the mandatory training records showed additional learning opportunities that were provided monthly to staff on relevant topics related to the patient group including self-harm. Best practice was shared within sessions led by an expert in the topic.

Individual supervision took place every four to six weeks and records confirmed this had happened within the last three months. Prior to this supervision was less frequent in the records we looked at. Both clinical and combined supervision took place. The combined supervision included management supervision. Group supervision was facilitated monthly by the family therapist. Supervision responsibility was clearly listed on the supervision tree displayed in the ward manager's office.

Appraisals are an annual meeting to review performance of individual staff, topics include objectives, personal development plan and mandatory employee learning plan. At Maple ward 25 out of 28 non-medical staff had had their appraisal within the last 12 months. Pine Lodge had achieved 21 out of 25 non-medical staff having had their appraisal within the last 12 months. An average of 87% of non-medical staff within the service had had an appraisal within the last 12 months.

Multi-disciplinary and inter-agency team work

Are services effective?

Good

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

Observation of the multi-disciplinary team meeting for Pine Lodge showed excellent communication within the team including specific issues relating to patients, risk assessment being completed prior to patients having leave off the ward.

Detailed daily handover sheets were in place which included the Mental Health Act status of the patients, levels of observation, health needs and information sharing. Previous daily handover sheets were stored securely in the locked office.

Education connections were very positive and patients accessed education on both sites. The education provision has been rated as outstanding by Ofsted.

Adherence to the MHA and the MHA Code of Practice

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.

Training in the Mental Health Act (MHA) was mandatory, renewable every three years. The trust target is 85% attendance, data provided by the trust showed 84% compliance with the training which is below their target.

At the last Mental Health Act reviewer visit at Pine Lodge on 22 January 2015, they were providing care and treatment in line with the MHA code of practice.

The Mental Health Act reviewer visit at Maple Ward on 8 April 2015 highlighted that there was inconsistency around recording that the responsible clinician had made an assessment of capacity to consent to treatment and whether or not the patient was consenting. During the inspection the care records that were reviewed had the capacity to consent to treatment recorded in the daily notes however this was quite difficult for the inspection team to find.

Good practice in applying the MCA

The Mental Capacity Act (MCA) does not apply to young people aged under 16. For children under the age of 16, the young persons' decision making ability is governed by Gillick competence. The concept of Gillick competence recognises that some children may have a sufficient level of maturity to make some decisions themselves. When working with children, staff should assess whether or not a child has a sufficient level of understanding to make decisions. The Mental Capacity Act does apply to young people aged 16 and 17.

Staff that were asked about the MCA advised of the policies available in the office and information on the trust intranet. However there was limited understanding of the Mental Capacity Act by staff and how it would relate to the patients that they were caring for. For example a staff member did not know at what age the Act applies from. All staff asked could not explain the five statutory principles of the MCA.

The training for Mental Capacity Act was renewable every 3 years. The trust target was that 85% had attended the training within the timescales. From the data provided by the trust 82% of the staff had attended the training within the timescales which is below their target. The training for MCA was an online training course. Staff had a varied understanding of the MCA and how this related to the service they worked in. There was some confusion amongst staff between the MHA and the MCA in relation to capacity and consent to treatment.

The principles of the MCA were on display as a flow chart in the ward manager's office.

Good

Are services caring?

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

Summary of findings

Our findings

Kindness, dignity, respect and support

We observed staff to be very respectful of the patients. On an occasion where a young person was distressed we were asked to move from the entrance to enable the young person to have the privacy and freedom that they required and deserved to move freely within the unit and access the outdoors.

Within education we observed positive encouragement and reinforcement which the patients responded positively to.

Team members were playing sport with young people on Maple ward, the young people seemed animated and to be truly enjoying the activity.

At Pine Lodge two young women were having their nails and make up completed by team members, in preparation for a ball they were due to attend. They spoke positively about the activity and seemed relaxed in the company of staff.

Of the ten patients interviewed, six young people said that you could talk to staff at any time, they were approachable, respectful and supportive. Patients said the staff had a good sense of humour. Patients reported that the environment was welcoming.

A patient felt comfortable in the environment, especially as the staff do not wear uniforms.

Three young people reported that at times, there are staff on who they do not know and it can be difficult to open up to them.

When being restrained a patient explained how staff were dignified and caring by using pillows to rest on as the patient had physical limitations.

There was an example of a young person complaining regarding information sharing, they reported receiving a verbal apology from staff.

A patient reported that a few staff did not communicate professionally with them, there was one complaint regarding communication and behaviour of one member of staff, records showed that additional support was put in place for the staff member to explain and mentor them in relation to supporting and communicating with patients. The learning was also shared at a team meeting and minutes showed the expectations for all staff to follow.

Staff at all levels, including the consultant psychiatrists and ward managers, were knowledgeable of each of the patients. They had knowledge of their past experiences which impact on their presentation and were genuinely pleased with the progress that patients had made.

The involvement of people in the care they receive

Patients reported being given a tour of the ward environment upon arrival. The welcome packs were a recent introduction, patients that had been in the service for more than two years or had been a patient on the ward over two years ago and had a readmission reported not receiving a pack. Two young people mentioned the headspace booklet that they received upon admission to the ward.

There was a section on the mymind website providing information about the service in a young person centred way, the leaflet included art work created by patients.

The community meetings were well attended and co-chaired by a patient and staff member. Patients were confident to contribute in the meeting. The patients were encouraged to set the agenda of the meeting. Topics discussed at the community meeting included what's on and goal setting for the day. One patient said that the community meeting was the setting where they would raise concerns. A patient reported the movement of some staff and the replacement with unfamiliar staff which was unsettling. They raised it at the community meeting and it was addressed and the situation improved.

Patients were informed of the advocacy service from a poster on display. One patient reported using the service. Other patients reported they would use the advocacy service if they were unhappy about the service. Patients knew the name of the advocate and the day they visited the ward.

Care records showed the involvement of the patient in the care plans and ownership was evident in the 'my anxiety

Good

Are services caring?

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

plan' and 'my coping skills plan' which were in place for some of the patients. There was not a facility for care plans to be signed by patients and then stored in the carenotes electronic record system. Printed versions were signed although the printed versions were not always the most recent version.

We observed an MDT for one of the patients. The meeting was attended by family and a number of professionals. The patient was invited to attend but declined.

Maple ward had minutes of community meetings that were held approximately every two to four weeks until June 2015 when there was minutes from weekly meetings. The meetings included a warm up exercise and information to share. It was noted that the young people had been informed at the community meetings of the CQC inspection.

Parents we spoke to told us that they were involved and updated on their child's care by phone and weekly meetings. If anxious, staff were able to offer reassurance to parents regarding their child's circumstances.

There was a comments box in Maple ward and a because our opinion matters board to capture suggestions from patients and the action that had taken place.

Patients were involved in the plan for the new building, a notice board showed updates on the building. Patients chose the colour scheme of the paint in the redecoration at Pine Lodge.

Are services responsive to people's needs?

Good

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

Summary of findings

Our findings

Access and discharge

The trust target for bed occupancy was 85% excluding leave. Information provided by the trust showed that Maple ward had 69% bed occupancy excluding leave and Pine Lodge had 51% from October 2014 to march 2015. When on leave the room remained that patients until they returned from leave.

Patients only moved between Pine Lodge and Maple ward when this was helpful for them. Usually patients were admitted to Maple ward when acutely unwell and then once they were more stable and able to engage in therapy they moved to Pine Lodge for a planned admission for treatment.

The outreach team was involved with young people via the MDT to facilitate discharge and provided a follow up after discharge. We were not aware of any delayed discharges within the CAMHS inpatient service.

The facilities promote recovery, comfort, dignity and confidentiality

Photographs of the staff team were at the entrance to the ward. Staff names included their first name and not their title with the aim of removing some of the barriers for young people upon admission who will experience heightened emotion.

The ward areas were very welcoming, with patients art work on display, including the outdoor space at Maple ward. The furniture was conducive to relaxation. At Pine Lodge there was a relaxation room with low level lighting, fibre optic and projection equipment available for use. There was a variety of rooms available for individual therapy sessions, space to have quieter time and larger rooms for communal dining and meetings. The patients were all clearly relaxed in the environment and had confidence in orientating around.

There was the opportunity for patients to make phone calls in private, patients could use their own mobile phones.

Feedback from the community meetings at Pine Lodge resulted in a change of supplier for food. Patients were involved in tasting samples from possible providers and contributed to the decision of the replacement provider.

One patient of the 10 we spoke to said the food on Maple Ward was poor. However it had improved since their previous admission.

Patients had access to cold drinks, at Maple ward there was a fob to access the water cooler in the dining room, dependant on risk assessment. If deemed not appropriate for the patient to have a fob they would be unable to access cold drinks independently. Hot drinks were made under staff supervision or by staff for patients.

Patients were able to personalise their own rooms and bring in their own belongings.

A variety of activities were taking place at the time of inspection including a trip to the museum and an art group. In the evening a quiz and bingo was planned. A trip to the zoo was discussed at the community meeting. A recreational timetable was displayed.

Patient-led assessment of the care environment 2014 data for Pine Lodge scored 93% for food and 94% for condition, appearance and maintenance of the building which was above the England average. However Pine Lodge scored 80% for cleanliness and 73% for privacy dignity and wellbeing which was below the England average.

Meeting the needs of all people who use the service

Pine Lodge was a building over many levels with several sets of stairs and was inaccessible to people with a mobility difficulty, this had been acknowledged by the trust and the new building which was underway should rectify the access barriers. Maple ward was all on one level and accessible to people with mobility difficulties.

Leaflets and information on display were in English, which was appropriate for the current patients. We did not see any leaflets in different languages. Accessible information was on display and available to take away on medication and treatments aimed at young people with plain English and colourful symbols included. Information was displayed on how to complain and the role of the PALS (patient advice and liaison service), advocacy information was

Are services responsive to people's needs?

Good

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displayed and young people confirmed they had accessed the support of the advocate. Information on the Mental health act and patients' rights were displayed in communal areas.

Listening to and learning from concerns and complaints

From the data provided by the trust, they had four complaints in CAMHS inpatients in the last 12 months. None were upheld or escalated to the Ombudsman. We reviewed the complaints record at Maple Ward, there were two complaints to view, the policy had been followed, patients had been supported to complain and PALS had been involved.

When patients made a complaint, this was investigated and the learning from the incident, including being more proactive, was shared with the staff team and recorded in the team meeting minutes. The patient also received feedback on the outcome of the investigation and changes in practice.

Information was displayed regarding how to complain. A patient confirmed they had complained and had received an apology from the staff regarding information sharing.

Are services well-led?

Good

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

Summary of findings

Our findings

Vision and values

Staff were aware of the trusts' six C's; care, compassion, competence, communication, courage and commitment. Patients had completed an art display on the values too. We saw the values embedded within the team. Staff were caring and showed compassion to the patients. Open communication was taking place amongst colleagues and senior colleagues for advice and guidance too.

The ward managers were approachable. Staff reported and we saw an open door policy. Staff were confident at seeking guidance from the ward managers. Staff reported receiving praise from senior managers both verbally and by email.

Good governance

Staff received supervision every four to six weeks, the dates were stored on the ESR electronic record system. There was a supervision tree in place to show who supervised who. The ward manager supervised the clinical leads. Clinical leads supervised the nurses and the nurses supervised the support workers. The administration team were supervised by the resource manager. There was an equal split of supervisions allocated to each of the clinical leads. An average of 87% of non-medical staff within the service had had an appraisal within the last 12 months.

We observed the majority of staff supporting and spending time with patients. Staff in the office were administration staff or nurses with a specific reason to be in the office, including processing a new admission.

Safeguarding was clearly understood by all staff, there were flow charts on display for patients and their families to use.

The Mental Health Act was thoroughly understood by staff however the Mental Capacity Act was not as well understood and staff had limited knowledge of how it related to the patients they were caring for.

The ward managers were supported by the resource manager, which was a new role. The resource manager had records and databases in place to monitor recruitment and selection, training, supervision and appraisals and sickness. The resource manager also coordinated the monthly training sessions for the team. There was administrative support in both settings, we observed positive interactions and knowledge of location of information and data.

Leadership, morale and staff engagement

Data provided by the trust showed that at Maple ward one person out of 39 had left the team in the last 12 months and had 2.3% sickness. Pine Lodge had three people leave out of 30 in the last 12 months and had 6.9% sickness.

There were no bullying and harassment cases in the service. Feedback from the staff was positive about working in the service. They were passionate about their role, and this was also evident in the interactions with the patients.

Two patients had complained at Maple ward, they had received the outcome either verbally from the ward manager or in writing from PALS. Patients confirmed they would feel comfortable discussing concerns at the community meeting and felt they would be listened to.

Governance flow charts and structural charts were on display in the ward manager's office.

Staff reported working in a supportive team with shared decisions regarding risk and mutual support following an incident. Group supervision and reflection was facilitated on a monthly basis by the family therapist. Support workers reported feeling part of a supportive team and felt valued. All staff we spoke to reported the ward managers were approachable and supportive.

Commitment to quality improvement and innovation

Maple Ward had been accredited with the Quality Network for Inpatient CAMHS (QNIC) as excellent in march 2014. There were areas for development from the review which the trust had completed. An issue log following QNIC reviews showed there was only one action outstanding. This was to update the carers pack to include guidance for carers on how to access a carers assessment. Pine lodge had had a visit from QNIC. However they had not applied for accreditation due to the building being unsuitable. The ward manager for Maple ward had been involved with QNIC as an assessor.