Requires Improvement

St Andrew's Healthcare

Child and adolescent mental health services

Quality Report

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Date of inspection visit: 9 -12 September 2014
Date of publication: 10 February 2015

Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
St Andrew's Healthcare - Adolescents Service	1-121538276	Bayley Heygate Church Fenwick John Clare Unit Heritage Elgar Richmond Watson Boardman	NN1 5DG

This report describes our judgement of the quality of care provided within this core service by St Andrew's Healthcare. 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.

Summary of findings

Where applicable, we have reported on each core service provided by St Andrew's Healthcare and these are brought together to inform our overall judgement of St Andrews Healthcare.

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 Child and adolescent mental health services	Requires Improvement 
Are Child and adolescent mental health services safe?	**Requires Improvement** 
Are Child and adolescent mental health services effective?	**Requires Improvement** 
Are Child and adolescent mental health services caring?	**Good** 
Are Child and adolescent mental health services responsive?	**Requires Improvement** 
Are Child and adolescent mental health services well-led?	**Requires Improvement** 

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

We identified that the service required improvements. The CAMHS service used methods of restraint such as “prone restraint”. The Department of Health guidance positive and safe: reducing the need for restrictive interventions, has criticised any use of prone restraint. The service equally did not always follow best practices in relation to managing complex behaviours and ensuring people had good access to health monitoring, in accordance with planned reviews of physical, emotional and psychological health.

We found there were some blanket restrictions in place. This was reflected in not only the practices we identified but also from what we were told by senior managers and staff working in the hospital. They recognised some aspects of the service required development and improvement to ensure high quality care was provided consistently to both children and young adults.

We found care plans were not holistic, personalised or recovery focused. Plans we looked at had not been developed with the children, young people or their relatives, carers or advocates. Where professionals such as occupational therapist and psychologists had been involved in assessing people’s needs and implementing treatment plans these were not always embedded in the day to day care plans which had been developed by the nursing team.

Many of the policies and procedures in place were hospital wide policies. The CAMHS service had very few policies and procedures which were specific for the CAMHS service. The philosophy of care was not child focused, for example staff we spoke to had limited knowledge and understanding of UN Convention of Children's Rights and important guidance such as Every Child Matters.

Summary of findings

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

Are services safe?

Although there was systems in place to ensure incidents were appropriately recorded, we found that improvements in relation to learning from incidents were necessary to ensure that people were safely having their needs met.

The service was using prone restraint which is regarded as unsafe practice because it could cause harm to people. We also found the service had not embedded and followed best practices in relation to minimising the use of restraint.

Requires Improvement

Are services effective?

We looked at how peoples care was planned and delivered and found the service required improvements. Although people had care plans in place these did not always follow best practice guidance. For example people using the service did not have positive behavioural support plans or health action plans. Where the service provided care and treatment to people with autism, sensory profiles had not been used to adapt the physical environment to ensure people's needs were being met.

Requires Improvement

Are services caring?

We observed how people were cared for and found people were spoken to in a dignified and caring manner. People who use the service spoke positively about those who cared for them.

The service had accessed the support from external agencies to support people with their needs and where people chose they had access to an advocacy service which supported them to make complaints and also assisted where they had any other support needs.

Good

Are services responsive to people's needs?

We looked at the arrangements in place for discharge and found generally most people did have discharge plans in place. One ward we visited had not been actively planning people's discharge which meant it was unclear what the longer term plan was for people.

There were some blanket restrictions in place in relation to imposing healthy lifestyles. Whilst a healthy lifestyle is important, it is equally important people are encouraged to take responsibility for their lifestyle choices.

Requires Improvement

Summary of findings

People were restricted in relation to the length of time they were able to make a phone call. It is important children and young people are supported to maintain relationships with their family and friends and unfortunately for some people due to their circumstances telephone is the only way this can be achieved.

People using the service also told us they often felt the complaints they made were not always responded to and that often felt their complaints were not taken seriously.

Are services well-led?

Requires Improvement 

Although staff told us they were happy in their work, they often felt detached from the senior managers in the organisation and did not think they fully appreciated the work and effort that was invested to ensure the safety, well-being and progress of the young people they cared for.

Majority of the policies and procedures in place were very adult focused and did not always meet the needs of children and young people. Senior managers told us that this was an area that required development and improvement to ensure the needs of children and young people were fully reflected in the organisations vision and values.

Summary of findings

Background to the service

St Andrew's offers medium and low secure specialist services for children with mild/moderate learning disabilities and challenging behaviour, including individuals who may also have a mental health problem and offending history. They also have care pathways and wards specifically for children diagnosed with autistic spectrum disorder (ASD).

The services are located at Northampton. We visited the CAMHS wards located in Northampton, accepting admissions for children with learning disabilities, autism and mental health conditions who meet their criteria.

Bayley ward is a medium secure inpatient ward that can accommodate up to 10 children and adolescents.

Heygate ward is a medium secure inpatient ward that can accommodate up to 10 children and adolescents.

Church ward is a low secure inpatient ward that can accommodate up to 10 children and adolescents.

Fenwick ward is a low secure inpatient ward that can accommodate up to 10 children and adolescents.

John Clare ward is a low secure inpatient ward that can accommodate up to 14 children and adolescents.

Heritage ward is a low secure inpatient ward that can accommodate up to 14 children and adolescents.

Richmond Watson is a low secure inpatient ward that can accommodate up to 12 children and adolescents.

Boardman is a low secure inpatient ward that can accommodate up to 10 children and adolescents.

Elgar ward is a locked inpatient ward that can accommodate up to 16 children and adolescents. Elgar ward is not part of the provider adolescent services. The service provides care for young people with a brain injury ward and is managed by the provider as part of the neuropsychiatry service.

Our inspection team

Our inspection team was led by:

Chair: Stephen Firn, Chief Executive, Oxleas NHS Foundation Trust

Team Leader: Nicholas Smith, Head of Hospital Inspection (Mental Health)

The team that inspected CAMHS consisted of one CQC inspector, a learning disability nurse, a health and well-being practitioner, a psychiatrist, an expert by experience and a Mental Health Act reviewer.

Why we carried out this inspection

We inspected this core service as part of our comprehensive inspection programme of independent health care providers of mental health services. This provider was selected to enable the Care Quality Commission to test and evaluate its new inspection methodology across a range of different mental healthcare service providers.

How we carried out this inspection

To get to the heart of people who use services' experience of care, 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 visiting, we reviewed a range of information we hold about the core service and asked other

Summary of findings

organisations to share what they knew. We carried out announced visits 9 – 11 September 2014. During the visits we talked with 18 people who use services. We observed how people were being cared for. We spoke with 27 members of staff, including nurses, doctors, support workers, ward administrators and a range of allied health professionals, including occupational therapists, social workers and dieticians. We reviewed 15 electronic care records and 12 Mental Health Act records of people who use services.

What people who use the provider's services say

Most of the young people we spoke with talked positively about the service they received. People told us staff were caring and supportive which enabled them to move onto other services.

People also told us they had care plans in place but did not always know what they were for or how they supported them to move on from the service.

The main criticism young people had was in relation to some restrictions in place but also felt their complaints were not listened and responded too.

Good practice

On some of the wards we visited we found the young people were key in the planning and delivery of care both individually and as a ward. The young people had taken ownership of the MDT process and drove this.

They had also worked with staff and developed a defining statement for what they would commit to as well as what the expected from the staff.

These included the following:

- Compassion - Is feeling yourself in someone else's shoes and thinking about how they feel.
- Staff promise to show compassion every day.
- Care – is looking after yourself, loved ones and others.
- Staff promise to take care of you and support you.
- Commitment – Is working hard and finishing what you started.
- Staff promise to stick by you every day and put you first.

We also found on an autism specific ward the service had embedded best practices in relation National Institute for Health and Clinical Excellence (NICE) guidance on caring for people with autism. For example the service had taken into consideration people's sensory needs, had developed augmented forms of communication for people and incorporated coping strategies as well as interventions for when people became distressed.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

- The provider must ensure that the service has a robust system in place to learn from incidents and ensure that the risk of harm is minimised.
- The provider must ensure that care plans and risk assessments are improved to ensure people receive care which is appropriate, safe and effective.
- The provider must ensure that managers and staff have knowledge in children's rights, to ensure care is planned in accordance with this.
- The provider must ensure that the service wide risk safety management system is adapted to ensure it meets with the specific needs of children.
- The provider must assess and treat patients based on individual risk and identified needs, rather than placing emphasis on generic, restrictive risk management processes, which are not in line with current Department of Health guidance.
- The provider must improve care planning in relation to restraint and ensure that best practices are followed.

Summary of findings

- The provider must ensure the service is following best practices by embedding positive behavioural support as a value and also ensuring where appropriate people have relevant support plans in place.
- The provider must ensure that agency and bank staff have adequate information about individual patient care and any safeguarding protection plans on the wards where they are working.
- The provider must ensure that information about the complaints process is clearly displayed on the wards in formats people can understand.
- The provider must improve how patient complaints are resolved and feedback given to the patient.
- The provider must ensure that independent investigations are undertaken if complaints are `upheld`. They should also review the process to ensure potential themes resulting from complaints that were “not upheld” are reviewed.
- The provider must review and stop the use of seclusion facilities for de-escalation and time out.
- The provider must ensure staff have training and understanding about safeguarding.

Action the provider SHOULD take to improve

- The provider should ensure that the risks, benefits and alternative options of care and treatment are discussed and explained in a way that the person who uses the service understands.
- The provider should promote better involvement of patients and their carers/family in writing and agreeing care plans and risk assessments and ensuring people have copies of these.
- The provider should consider ways of re-structuring set nursing teams and shifts, in order to enable a comprehensive handover and nursing discussion and reduce the reported inconsistencies and conflict between set teams.
- The provider should address the impact that staffing arrangements are having on patients accessing activities, outside space and leave arrangements.
- The provider should engage with staff to understand how policies and procedures can be adapted to meet the needs of the CAMHS services.
- The provider should review patients’ long term placement options that have been in extra care facilities for prolonged periods of time.

St Andrew's Healthcare

Child and adolescent mental health services

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Bayley	
Heygate	
Church	
Fenwick	
John Clare Unit	St Andrew's Healthcare - Adolescents Service
Heritage	
Elgar	
Richmond Watson	
Boardman	

Mental Health Act responsibilities

The CQC Mental Health Act reviewer and inspectors looked at 12 records, including seclusion records, across the wards we visited. They found that the records were kept accurately and in line with the Mental Health Act code of practice.

When they checked the T2 and T3 medication records, they found that these were not always accurate. Some specified medication that the person was no longer taking, or did not always represent the dosage of medication the person was taking, which was over the BNF recommended limit.

Patients we spoke with were aware of their rights. Section 17 leave and access to visitors, including solicitors, was used in conjunction with the generic risk safety system. This was not in line with Mental Health Act code of practice, Chapter 19, which has clear guidance regarding restriction or exclusion of visitors.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

Our specialist advisor spoke with a number of consultant psychiatrists, who demonstrated an understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff we spoke with were also able to demonstrate a good knowledge and understanding of the Court of Protection and when they may be required to make an application for an order. The Mental Capacity Act 2005 does not apply to people under the age of 16.

Requires improvement

Are services safe?

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

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

Summary of findings

We looked at the systems in place to ensure people who used the service were safe. Although there were systems in place to ensure incidents which had occurred were appropriately recorded, we did find improvements in relation to learning from incidents were necessary.

We looked at the arrangements in place for the use of restraint and found improvements were necessary to ensure people's safety. We found the service was using restraint methods which have been criticised by leading professionals as unsafe. The service had not embedded and followed best practices in relation to minimising the use of restraint.

Our findings

Safe and clean ward environment

We looked at the design layout, and cleanliness of all the wards where young people were cared for and found the environment was safe and suitable. We looked at all areas of each ward and identified no ligature issues. For example bathrooms people had access to did not have fixtures and fittings which could be used for self-harm.

We also looked at the seclusion rooms for each of the wards and found them to be of suitable standard and met the expectations of seclusion rooms as set within the Mental Health Act 1983 code of practice. For example there was clear visibility into each of the rooms to ensure people could be closely monitored whilst the room was occupied. There were no objects or fixtures/fittings that could be used for self-harm. We also found the rooms were adequately lit, they were sufficiently ventilated and also had reduced sound but not to the point where it was sound proof. They also had toilet facilities where people could access when required.

We looked at the furnishing and decoration of each of the wards and found the environment promoted the dignity of those who use the service. For example all wards had furniture which was in good condition and suitable for the ward environments. We found the internal decoration was to a generally good standard on most wards. Wards where we identified improvements could be made we were assured by managers that lack of general maintenance was due to reasons such as the wards were being moved to new locations on the site.

We spoke with the managers of each ward and asked details of how audits of the wards were carried out in order to ensure the environment is safe. Each ward manager explained to us a quality assessment is completed on a monthly basis to ensure the environment is adequately maintained to ensure the safety of the young people using the service. They also told us that daily checks were also carried out and where concerns had been identified they would report to relevant management team for immediate action.

We asked the ward managers how infection control was monitored. We were informed the service had an appointed infection control lead that would complete monthly audits to ensure the wards were of suitable cleanliness. We found although there were no antibacterial solutions around the entrances of the wards they were situated in the nursing offices where patients did not have access. Managers and staff we spoke with told us they were unable to have antibacterial solutions positioned on the wards. This was because there had been incidents where people tried to drink the solution which could cause harm.

Safe staffing

We looked at the staffing levels on each ward to ensure they met the needs of people. We looked at the staffing rotas on each ward and asked the managers about how dependency assessments were used to identify staffing levels. The managers of each ward told us the wards used a dependency tool to assess the staffing levels required and this was based on individual needs and risks. Managers told us where additional staffing was required they had access to bank and agency staff.

All wards had developed a system where they predominantly used the same staff from their "bank" to cover shifts where there were gaps. Each ward told us they

Requires improvement

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would almost always have the same staff from an agency or bank. This provided consistency for people because staff were aware of individual care needs and the children and young people were familiar with the staff.

We did observe one member of bank staff asking nursing staff the care needs of one person to whom they were responsible for caring for. The staff member was not clear of the person's complex needs or the care plans and risk assessments in place. The nursing assistant we spoke too said this was often a problem because bank staff did not always have access to the hospital computer system.

People who use the service told us when the hospital used bank staff it often meant they may be treated and cared for differently because they were not always aware of their needs..

Although it was clear a system was in place for attempting to ensure people received care from staff they were familiar with and who had an understanding of their needs. It was evident from our observations and information we were told by patients, bank and agency staff did not always have a detailed understanding of people's needs. Not having a robust system in place to ensure staff working with people have a detailed understanding of their needs places people at risk of receiving inappropriate or unsafe care.

People using the service told us that there were occasions when they were not able to have the granted leave they were entitled too because a staff member was not available to act as an escort. We spoke with the managers of each of the wards and also to staff. They told us they sometimes "struggled" to always meet the demands of some patients with regards to leave because ensuring the safety of the ward environment was paramount. They told us that if someone was unable at a particular time to enjoy their leave they would be given it at a later time during that day. This was reflected in the reports the service submitted to its governance team on a weekly basis.

Overall, we concluded that there were sufficient nursing and support staff on each of the wards we visited to ensure people's safety was maintained. However, we would expect the provider to have regard to the comments made to us by people who use the service, in relation to meeting the needs of people so they are able to enjoy their granted leave away from ward areas.

We spoke with senior clinicians during our visit and questioned the arrangements in place to deal with medical emergencies. We were told the arrangements were two doctors between 5-11pm and then one doctor waking cover and one on call between 11pm and 9am. The responsibility was to cover 550 beds which is essentially the entire hospital. The doctors we spoke with told us they were responsible for all emergencies as well as attending any seclusion that had taken place. We asked if there had been any occasions where they were unable to respond to any medical emergencies but were told no. We were however told by one clinician who worked nights that it was always busy and often felt overworked as they had to attend to medical concerns as well as seclusions which were all time consuming.

Assessing and managing risk to patients and staff

We looked at the care records of 16 people across the wards and found that each person had an assessment of their care which detailed their individual risks. It was clear from the records this had been done at the point of admission and was updated on a monthly basis.

We looked at the arrangements in place to manage risk on the ward and found that some practices were restrictive. For example on Elgar ward young people and staff both explained that everyone was searched on their return from unescorted leave. We were told by nursing staff this included young people who were not detained under the Mental Health Act 1983. There were no arrangements in place to obtain consent.

There was a new admission to one ward during the time of our inspection the young person was detained under a section of the Mental Health Act 1983. The decision had been taken to nurse this young person on three to one staffing levels in an area away from the main body of the ward.

Over the period of the afternoon we met this young person three times. On each occasion they were settled and calm there were no signs of agitation or aggression that would indicate they needed to be nursed in segregation. When this was discussed with the clinical team, they explained the decision was made due to potential risks and to allow controlled integration into the main ward environment. We asked if this was documented anywhere and whether a review system had been introduced to evaluated and review the decision. We found no process was in place. We were told by the clinical team this was general practice when admitting people to the ward.

Requires improvement

Are services safe?

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

We found the first method of restraint used was that of "prone position". The Department of Health Guidance "positive and proactive care: reducing the need for restrictive interventions" was introduced in order to abolish the use of what is regarded as historical practices. It was concerning that St Andrew's had not adopted at ward level the philosophy of the guidance set out within Positive and Proactive care.

It was equally evident looking at the care records the MDT had not considered the emotional and psychological impact of using such methods where people had been previously subjected to abuse or had witnessed abuse. We brought this to the attention of the registered manager who acknowledged our concerns and told us improvements would be made.

We spoke with a variety of staff including clinicians, managers, nurses and support staff and found they had received training in identifying and reporting abuse. Staff were able to tell us how they would respond to incidents of abuse and allegations of the same. We found that people were aware of the organisations' internal processes of reporting abuse but were not always aware of to which external agencies they should report concerns; such as the local authority safeguarding team, the CQC and the police. This was despite there being posters displayed within staff areas giving staff clear instructions.

Young people we spoke with told us they would sometimes be bullied by other patients on the wards and this would sometimes cause them distress. We looked at the care records of two patients where it was detailed in their case notes they were bullied by other people on the ward. We asked the ward manager what arrangements had been put in place to ensure the person's safety. We were told by the ward manager and the person's psychologist that people were continually on view of staff and therefore no further safeguards were necessary. The ward had not considered the use of protection plans to keep people safe where they had been identified as being at risk of abuse. We found the response to our concerns by the ward manager to be inadequate. We informed the registered manager who acknowledged our concerns and told us improvements would be made.

We looked at the seclusion register held on each ward and the incident recording system (datix) and found improvements were required. For example the recording of seclusion did not comply with the Mental Health Act code of practice 1983. Two-hourly reviews had not been completed as required as soon as practicable after the seclusion had commenced. On occasions, the attending doctor had either not attended or had not signed the seclusion records to indicate that they were happy with the seclusion or stipulate it had been reviewed.

When the young people had been administered emergency medication prior to seclusion this was not indicated on the record and there was no evidence that the required observations had been completed nor was there any justification for these not being completed. Failure to complete records accurately following serious interventions places people at risk of harm as it is not clear that such interventions have been authorised by the most senior person responsible.

We looked at the systems for the management of medicines at the service. The service used a monitored dosage system from a pharmacy and there were records to demonstrate that these were checked when the service received the medicines, and any discrepancies addressed promptly.

Medicines were being stored securely at the service. We looked at the care records of five people and found that where they had allergies to certain medicines this was recorded clearly on the person's records. We also found where people were prescribed "as and when required" medicines there was a clear protocol in place to ensure staff were aware of the circumstances the medicines should be administered.

Medicines were safely administered. We checked the medicines stock for five people and looked at their medication administration records (MAR) and found that medicines were signed to reflect the prescriber's instructions. This meant people received their medicines appropriately.

We looked at care records for people who required cream and found the service had a protocol for care staff to apply the cream in accordance with the prescriber's instructions.

The service carried out regular daily and weekly audits to ensure that medicines had been administered properly and also to ensure that any errors or discrepancies could be addressed promptly.

Requires improvement

Are services safe?

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

The service also carried out medicine competency assessments of staff to ensure training was effective. This also reduced the risk of people receiving medication by unsafe practices.

The service had adopted the principles of Royal College of Psychiatrists (2007) Challenging Behaviour: A unified approach and clinical and service guidelines College Report CR 144). Where people were prescribed antipsychotic medication care plans stated why the medication was prescribed and what its benefits were and also ensured medication was regularly reviewed.

Reporting incidents and learning from when things go wrong

All the staff we spoke with were able to tell us how incidents were reported and all nursing staff were fully informed of how to use the hospital reporting system.

We looked at the incident records of patients and identified they were not always detailed regarding the actions taken to manage the incident or sufficient detail regarding potential triggers for the incidents.

We identified one incident where a number of patients had become anxious, distressed and agitated at the same time which led to three people attempting to harm themselves intentionally. We spoke with the registered manager regarding the incidents and spoke about what learning had taken place following the incidents.

The information provided was not satisfactory. The registered manager told us a meeting had taken place with the people concerned and the ward manager. We were told a further meeting had taken place discussing the incident with staff. We would have expected an MDT approach to the incident where possible triggers could have been identified to reduce the risk and possibility of similar things occurring again. We found in relation to one person who had been involved in the incident they had few days later attempted to harm themselves again.

We spoke with the registered manager who acknowledged our concerns and told us there was not a formal process for learning from incidents and stated that it would be something which could be introduced.

The service had sent daily and weekly updates to the quality assurance directorate within the hospital and managers attended a monthly meeting to discuss risk factors on their wards relating to patients. This suggests there was a formal process for reporting and discussing incidents but this had not been developed at ward level to ensure a robust system was in place for a MDT approach to managing risk.

Are services effective?

Requires Improvement

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

Summary of findings

We looked at how peoples care was planned and delivered and found the service required improvements. Although people had care plans in place best practice guidance was not being followed. For example people using the service did not have Positive Behavioural Support Plans or Health Action Plans. Guidance relating to ensuring people's sensory needs were met had not been embedded as the physical environment on one ward required improvement.

Our findings

Assessment of needs and planning of care

We looked at the care records of 16 people across nine wards and found that's they were not personalised, holistic and recovery focused. Improvements were required.

The service used the support plans "my shared pathway" which is evidenced based practice and each person had a copy of the plan if they wished. People we spoke with told us they were aware of their plan and its contents but did not understand what it was for.

We found there was a range of professionals involved in people's care such as psychologists, occupational therapists, speech and language therapists, psychiatrists and also nursing and support staff that were responsible for the day to day delivery of care.

We identified that each professional would input their reports and recommendations onto each person's case notes but the detailed information provided was not always transferred in the care plans of individuals which meant that there was not always a unified approach to delivering care.

For example where people displayed behaviours such as inappropriate sexualised behaviour there was information in psychology reports which detailed strategies and interventions staff could use to manage people's behaviour. This information was not detailed in the daily care plans staff used to support people. We spoke with nursing staff and they were unable to explain the strategies and interventions identified in the psychology reports which meant they were not reflecting on this information whilst planning and delivering people's care.

We spoke with managers and support staff regarding our findings who acknowledged our concerns. The feedback we received was the system used for reporting and writing care plans is of a complex nature. Nursing staff told us it was often difficult to find the information but accepted daily care plans regarding strategies and interventions could be improved.

We looked at how people's physical health care needs were managed and found although people had physical examinations when they were needed and were referred to a health professional when required, the service had not followed the Department of Health's Guidance on health action plans. None of the young people with autism or learning disability had a plan in place. A health action plan details the support required so people with learning disabilities and autism can lead healthy lives. It identifies potential health concerns and promotes a positive well-being for the person identifying the emotional and psychological needs of individuals. None of the people residing at St Andrew's benefited from this approach to maintain positive healthy lives despite some people on some wards having a learning disability and/or autism.

Best practice in treatment and care

We looked at the medication practices within the service and found clinicians working in the service had adopted the principles contained with Royal College of Psychiatrists (2007) Challenging Behaviour: A unified approach. Clinical and service guidelines college report CR 144 because clear reasoning was detailed regarding the use of antipsychotic medication where people displayed aggressive, violent and disturbed behaviour.

It was also evident that people's medication was continually reviewed and where changes had occurred these had been done within the legal framework. However we did bring to the attention of clinicians one example of where appropriate legal steps had not always been followed in relation to prescribing medication under the Mental health Act 1983 documentation.

We spoke with psychologists working in the service and were told of a range of psychological therapies used to support people with their mental health conditions. For

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example treatments relating to sexualised behaviour were used, anger management programs which focused on coping strategies and a range of cognitive behavioural therapy (CBT) and dialectical behavioural therapies (DBT).

People we spoke with told us they benefited from the treatments and stated they helped them improve in the development of psychological well-being.

We looked at how the service followed best practice in relation to managing challenging and complex behaviours and found improvements are required. For example people who had complex challenging needs did not have positive behavioural support plans is place. The guidance published by the Department of Health Positive and Proactive Care: reducing the need for restrictive interventions April 2014 sets out the expectations of providers to minimise and reduce the need for physical intervention.

Nursing and support staff we spoke with had limited understanding of positive behaviour support. Other staff such as psychologists told us training was being developed. We were concerned many patients had been in the service for many years and yet did not benefit from this approach.

We also found where people had sensory needs relating to noise, wards were still in the process of upgrading their facilities to ensure these needs were met. This meant the service was not always meeting the expectations of NICE Guidelines CG142 Autism: recognition, referral, diagnosis and management of adults on the autism spectrum.

We saw evidence in case records that people did have access to doctors and other health staff when they required medical help. We saw in records of one person where they had inserted objects into themselves they had been referred to a specialist consultant to discuss the treatment required to have the inserted object removed.

We also saw in another person's records where they had a specific health condition they had been referred to another consultant to seek advice regarding the medication and treatment required to treat the person's health condition.

We looked at the records of five people where they had accessed health care services and spoke with some individuals. People who use the service told us "I can see the doctor when I need to, I have recently seen a doctor because I had cold."

We found the ward had a range of activities available to people throughout the day and weekend which included independent living skills, recreational meaningful activities and also educational skills by way of teaching.

People who used the service told us they enjoyed the activities available and did not get bored, however they expressed disappointment when activities were cancelled because staff were not always available.

We looked at how the service delivered "opportunity and goal planning" and found improvements could be made. For example where one person stated in their care plan they were interested in becoming a mechanic there was no details in the person's support plan about how they would be supported to achieve this goal in terms of education and work experience.

We found the attitude of some staff dismissive. One member of staff told us "they are children, they change their minds regularly what they want to do when they get older and some of the goals are not realistic". People should be appropriately supported to achieve their aspirations. Failing to do so is detrimental to the long term well-being of young people with mental health conditions.

We spoke with staff and mangers on each of the wards about their understanding of children's rights and the UN Convention of Rights of the Child and also the Children's Act. We found the knowledge of most managers to be very limited. For example staff were unsure what we were referring too and how that impacted on the care young people received. Staff told us they had not received any specific training on either of these topics.

We saw examples of where training would have proved beneficial. For example where people had difficult relationships with their families a child's right to have a voice and be party to decisions was absent. Clinical and nursing staff had limited knowledge to ensure their rights were taken into account as in accordance with UN Convention and the associated articles contained within it.

The service had a safety risk management system and depending on what level a young person was judged at depended on the privileges they could have in terms of escorted supervised and unsupervised leave. We found that the same restriction levels were applied elsewhere in

Are services effective?

Requires Improvement

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.

the hospital and that they were not child focused. For example each young person did not have their own individual plan with objectives on what they needed to achieve to enable them to have further leave privileges.

We spoke with ward mangers who acknowledged our concerns with the system and told us they would make improvements. One manager was able to show us in relation to one person where they had developed an individual plan because the person's cognitive abilities meant they were unable to understand the hospital safety levels and what was expected of them.

We found clinical audits were completed. Managers we spoke with told us about their responsibility to monitor activity engagement and where this fell short other professionals such as psychologists and occupational therapists were involved in improvements. We were told by ward managers that staff engaged people proactively in activities and that these were measured on a monthly basis regarding enjoyment and engagement of the task/activity provided.

Skilled staff to deliver care

Each ward we visited had its own input from a range of professionals such as pharmacists, occupational therapy, and psychology. It was evident that they played an active role in the wards as during our visit we observed them engaging people in activities such as football, and other sports as well as doing individual sessions with people around sexuality and sex.

We spoke with one psychiatrist who told us how engaged the pharmacy team were at St Andrew's. They were able to explain in detail how audits had identified issues in prescribing practices and this enabled improvements to be made immediately.

We spoke with a range of professionals including nursing and support staff who told us they received suitable training with the exception of specialised training in positive behaviour support and children's rights. Staff told us they were appraised on a yearly basis. We were unable to look at supervision records relating to topics discussed, because each member of staff kept their supervision records personally and these were not stored on the hospital system.

We spoke with staff about group supervision and reflective practice. They told us this was something they engaged in. One ward we visited told us reflective practice was led by the ward psychologist. It was evident looking at records held on the system that reflective practice took place. We saw a full group discussion had taken place for one person where the service struggled to engage with them due to the complex needs of the individual.

Multi-disciplinary and inter-agency team work

The service had developed relationships with community mental health teams care co-ordinators and local authority social services. This was generally done on initial admission to the service or when a person was discharged.

We were able to identify that when people were discharged the CAMHS service had engaged with external partners to support with a smooth transition between services. It was evident in records this was very MDT lead. We were able to see how the service engaged individuals within that process by giving them an opportunity to visit future placements.

We did find however for one ward there had been a lack of discharge planning. For example it was a rehabilitation ward and only one person had a discharge plan in place. We spoke with the ward manager and asked what further arrangements were in place regarding other people on the ward and were told "we have only started to think about discharge plans." This had concerned us given that some people had been on the ward for years and this had not been a consideration.

Adherence to the MHA and MCA Code of Practice

The CQC Mental Health Act reviewer and inspectors looked at 12 care and treatment records, including seclusion records, across the wards. They found that the records were kept accurately and in line with the Mental Health Act code of practice.

When they checked the T2 and T3 medication records, they found that these were not always accurate. Some specified medication that the person was no longer taking, or did not always represent the dosage of medication the person was taking, and was over the BNF recommended limit.

Patients we spoke with were aware of their rights. Section 17 leave and access to visitors, was used in conjunction with the generic risk safety system. This was not in line with Mental Health Act code of practice, Chapter 19, which has clear guidance regarding restriction or exclusion of visitors.

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Good Practice in applying the MCA

Some areas of practice were in line with minimum safety standards of low and medium secure settings. However, we were concerned that there appeared to be routine restrictive practices in place to manage risk. Some of the blanket restrictions relating to people having time off the ward and visitors were not in line with the principles of the Mental Capacity Act or Mental Health Act.

Our specialist advisor and inspectors spoke with a number of consultant psychiatrists, nursing staff and support staff , who demonstrated an understanding of the Mental Capacity Act. The ward social workers took a lead role in identifying when there may be indication to use deprivation of liberty safeguards.

Good

Are services caring?

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

Summary of findings

We observed how people were cared for and found people were spoken to in a dignified and caring manner. People who use the service spoke positively about those who cared for them.

The service had accessed the support from external agencies to support people with their needs and where people chose they had access to an advocacy service which supported them to make complaints and also assisted where they had any other support needs.

Our findings

Kindness, dignity, respect and support

We observed how people were cared for on each of the wards we visited and found people were treated with dignity and respect.

Nursing and supporting staff showed interest in the young people they cared for and a willingness to ensure that each person was able to have a meaningful and fulfilling life.

One nurse commented "many people come from difficult situations and as well as being a nurse we have to parent some of the young people because they are so young."

We saw staff engaging people in age appropriate activities such as table tennis and games. All of the wards we visited had calm and relaxed atmosphere where it appeared both staff and patients had a mutual respect for each other.

Young people we spoke with talked positively about the staff who cared for them. One person told us "they really help me, I wouldn't be as well now if it wasn't for them".

Another person told us "you get on with some better than others but they are all good, nobody treats us bad".

We looked at how the wards met the equality and diversity needs of people and found people were supported. For example we saw in some people's records where they struggled to understand their sexual identity that the organisation had made links with external charities and network groups to come to the hospital and talk to people on an individual basis.

We asked the ward managers if there were any patient LGBT network groups they could join as well as any other groups and were told these were all accessed externally. This meant that people did not always have the opportunity to participate in group equality and diversity networks. This is an area the provider could improve.

The involvement of people in the care they receive

We asked patients about the admission process and how they were oriented to the ward. We found on one ward patients had been involved in developing a booklet for all other patients who came to the hospital. The booklet contained information about the facilities available at the hospital, how people could complain and also information regarding advocacy.

Patients we spoke with told us they were able to access advocacy services when they wanted. We were told by ward managers that representatives from the service came to patient meetings and helped people make complaints if they needed to and support them in any other areas they raised issues about.

People had a care programme approach (CPA) meetings. We spoke with each of the ward managers who told us many patients because of their age and understanding tend not to lead their CPA. All ward managers we spoke with told us they want people to lead their CPAs and understand the importance of doing so.

We spoke with young people about their involvement in care planning and most of the comments we received were "I know I have a care plan but I'm not sure what it is for."

We looked at how people's family and carers were involved in care plans and found for many that there was no involvement. We spoke with nursing staff on the wards and they explained that due to many family dynamics it was difficult to engage relatives and family friends. Staff told us they did the best they could.

We looked at visitor records to the wards and did find there was an absence of family visits but young people we spoke with told us they were able to use skype and other electronic ways of staying in touch with their family and friends.

One ward manager told us about one person who had friends that came to visit one young person on planned

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visits and they were able to show us documentary evidence this had occurred. The manager was able to show us they had arranged the visit and worked with other external health professionals to enable the visit to proceed.

Requires Improvement

Are services responsive to people's needs?

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

Summary of findings

We looked at the arrangements in place for discharge and found that in general most people did have plans in place, except on one ward where it had not been actively planned which means people's progress was not considered.

There were some blanket restrictions in place in relation to imposing healthy lifestyles upon people, and whilst a healthy lifestyle is important it is equally people are able to take responsibility for their lifestyle choices.

We also found people were restricted in relation to the length of time they were able to make phone calls for. It is important children and young people are supported to maintain relationships with their family and friends and unfortunately for some people due to their circumstances telephone is the only way this could be achieved.

People using the service also told us they often felt the complaints they made were not always responded to and that often felt their complaints were not taken seriously.

Our findings

Access, discharge and bed management

On most wards we visited discharge was a key principle and was planned at the point of admission. However one ward we visited we found there was an absence of discharge planning. We spoke with the registered manager who acknowledged our concerns and told us this had been highlighted as an area of improvement. They explained to us that CAMHS does not have an overall clinical lead unlike other parts of the hospital and this can often mean that wards prioritise their work in different ways.

We asked what arrangements were in place when people were on agreed leave or were going through a transition period to new placements. We were told people's beds were fully available until they were discharged which meant the service did not fill unoccupied beds until the person was fully transferred.

We looked at how people were moved around the hospital and found it was dependant on their progress. People would be moved from admission wards to other longer stay wards once their course of treatment had been identified. Ward managers told us people would not move people for any other reason unless there were any safeguarding issues which meant people did require to be moved. We saw in the records of one person on one ward were they had been moved to another ward because they were bullied by other people on the ward and the situation was becoming untenable for the person.

The service had a number of what they referred to as "extra care" beds. These were generally segregated from the main parts of the ward and people were cared for in isolation. We spoke with the staff and ward managers regarding the provision of this service and were told the hospital policy on the use of "extra care" beds was ambiguous and didn't really define what was meant.

The ward environment optimises recovery, comfort and dignity

Each ward we looked at had a range of facilities which included a treatment room and activity rooms so people could have their clinical care needs met and also a place to enjoy recreational activities.

Some wards we went to had designated spaces for people to meet with relative and friends. Where some wards did not provide these facilities there were spaces within the hospital facility where people could meet with their family and friends.

We saw on each of the wards there were telephone facilities so people could contact their friends and relatives in a private place to ensure privacy.

Some of the wards we went to had an outside space where people could play all weather sports such as football, netball and basketball, as well as enjoy the freedom of being outside in a safe environment.

Although some other wards did not have all of the facilities as detailed above, they did have space where people could enjoy fresh air.

We looked at what accessible information was provided to patients and found care plans (my shared pathway) were written in an easy read format. The service had a complaints policy which was also available in an easy read format and was displayed on most wards we visited. We also found that there was a patients' rights handbook which had been completed in an easy read format. Patients

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we spoke with told us they were happy with the way that information was provided. One person told us "I understand most of the information and if I don't the staff help me". We did find that some of the information was still targeted mainly for adults and therefore the service could improve by designing accessible information for children.

Young people we spoke with were happy with the food, but did state that portions sometimes were too small. They told us they were encouraged to eat healthy and they were allowed two snacks per week. This was confirmed when we spoke with staff. Young people told us that food was often a discussion on the patient ward community meetings where they are given opportunity to discuss the types of food they would like. The service had recently appointed a new cook and patients told us food quality was much better than it had been previously. One person told us "the chef came to our community meeting and asked us what types of food we wanted". This demonstrated patient views were seen as important when preparing menu choices.

Ward policies and procedures minimise restrictions

There were some blanket restrictions in place such as on thw John Clare Unit young people were prevented from having sugar due to the healthy eating initiative that the hospital had developed.

We were told this was patient lead by senior managers but the wards we visited told us it was hospital driven. Whilst CQC agrees that hospitals should promote healthy eating it is equally important that detained patients should enjoy equal rights as others about choosing a diet they want and supported to make healthy choices to improve health and well-being as opposed to have ideals put upon them.

We also found there were restriction regarding the use of phone calls such as people were only allowed 20 minute calls on an evening. Whilst therapy is important it has to be appreciated that a 20 minute phone call on an evening when many young people do not have the opportunity to see their relatives for weeks is restrictive. The hospital needs to consider the needs of children and the importance of young people to develop and maintain their relationships with their family and friends.

We looked at the bedrooms of some patients with their permission and found that they had been personalised in the way in which they chose. Patients told us that staff were generally relaxed about what they put on the walls "as long as it wasn't pornography".

Listening to and learning from concerns and complaints

People we spoke with told us they knew how to complain but often felt they were not listened to. People told us they had made complaints about bullying on the wards by their peers but this often was ignored by staff and although the paperwork was completed they did not get any response from the senior teams.

We spoke with staff regarding some of the comments we had received and they told us that once the matter had been investigated they were usually asked to discuss the feedback with patients.

Are services well-led?

Requires Improvement

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

Although staff told us they were happy in their work they often felt detached from the senior managers in the organisation and did not think they full appreciated they work and effort that was invested to ensure the safety, well-being and progress of the young people they cared for.

Staff we spoke with told us that most of the policies and procedures in place were adult focused and therefore the CAMHS service had very few specific policies that related directly to them. Senior managers told us this was an area that required development and improvement to ensure the needs of children and young people are fully reflected in the organisations vision and values as well as policies and procedures.

Our findings

Vision and values

Staff and management we spoke with told us they were aware of the organisation's vision and values and were able to explain them to us but they told us they felt they were not always directly linked to CAMHS services and they mainly focused on adult services and would like to see a new approach to CAMHS.

Staff told us they were aware of who the most senior managers in the hospital were and told us they had visited the ward, but equally told us they often felt underappreciated by those senior managers and often felt not listened to. One manager gave us an example of a presentation they had delivered to a senior management team because they felt the organisation had little understanding of the working complexities of CAMHS.

Good governance

All of the wards we visited had governance processes in place. Managers were able to demonstrate to us their autonomy in being able to recruit staff when it was required. During our visit one ward we had visited had recently recruited two nurses. The manager told us they were their choice and that no person had interfered in the process of the recruitment.

We also saw examples of where managers were able to request additional staff when it was identified as a required need.

We found that staff had received mandatory training and the wards had a "dashboard" which gave them statistical data on the training which staff had completed and the training which was necessary. All of the wards we visited had relevant training plans in place and majority of staff were up to date with those. Managers told us where staff had not completed training this was discussed during one to one sessions.

Staff we spoke with told us they received regular supervision, appraisal and reflective learning. We were able to see looking through documents on the wards we visited that these aspects happened on a regular basis. Each ward had an administrative assistant who kept records relating to staff supervision and training which we were able to see. We were also able to see in patient records where reflective practice had taken place.

Staffing rotas we looked and observation of staff levels the service were able to demonstrate that there were sufficient and adequate mix of both nursing staff. This meant that the wards were able to effectively manage incidents and also provide a therapeutic environment for people.

Each ward used a system call datix to record incidents and we were able to see incidents were reported to other directorates such as quality and risk and monthly reports regarding incidents were produced which meant the service was able to regularly assess ward activity.

Each ward was able to tell us about the safeguarding, Mental Health Act and Mental Capacity Act monitoring arrangements the provider had in place and from the records some areas needed improvement.

Patients we spoke with told us the often felt that complaints made were not listened too and told us they often did not get feedback from the complaints raised despite staff telling us this did occur. The provider may wish to reconsider its process of dealing with complaints from children to ensure people feel valued and their opinions regarding their care are fully considered.

Leadership, morale and staff engagement

Staff we spoke with told us they enjoyed working with their managers and if they had any concerns they were able to confidently raise that with them. Ward managers we spoke

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with told us that there was generally a low level of sickness on their wards and where there had been or was sickness this was generally due to long term health conditions that were unavoidable. However we did find sickness levels in CAMHS was overall higher than the overall sickness across the organisation. The sickness absence rate at St Andrews was 4.11% in June 2014 in the adolescent service the rate was 5.35%.

Staff told us they were able to raise any concerns they had with their ward managers but they often felt unable to with more senior managers in the organisation. One person told us "I have worked here for over 14 years and it is the ward staff that make my job enjoyable. I just come to work and spend my time on the wards I avoid getting involved with senior managers".

Commitment to quality improvement and innovation

Each ward has to complete regular daily and monthly data entries which inform the performance of each of the wards and this is monitored on a monthly basis through governance meetings. Wards are regularly visited by the quality teams and where shortfalls are identified then action plans are put in place to ensure improvements were made. We did not see any of the action plans during our inspection but the Registered manager was able to inform us of the areas of improvements which had been identified.

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **How the regulation was not being met:** The service had not followed best practice in relation to people have positive behaviour support plans where appropriate. Managers and staff had a very limited understanding of children's rights which meant care was not always planned in accordance with children's rights. The service had a risk safety management system which was not designed for the specific use of children's services and was not person centred. Regulation 9 (1)(b) (i) (ii) (iii)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **How the Regulation was not being met:** There were not clear systems to ensure that agency and bank staff were aware of the care needs of people. Restraint care plans and techniques required improvement. The hospital policies and practices do not meet current best practices. The methods of restraint used can place people at risk of harm. The service does not have a robust system in place to learn from incidents and ensure that the risk of harm is minimised.

Compliance actions

Regulated activity	Regulation
	Care plans and risk assessments required improvement to ensure people received care which was appropriate, safe and effective. Seclusion facilities were being routinely used for de-escalation and time out and not recorded as seclusion. Regulation 11 (1) (a)
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints **How the Regulation was not being met:** Information about the complaints process was not clearly displayed on the wards in formats people could understand. We found that patients told us that they did not feel that their complaints were always listened to or acted on. Patients told us that they did not get always feedback from their complaints. Regulation 19 2(a) (b) (c)