St Andrew's Healthcare - Adolescents Service

Quality Report

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

Overall summary

We did not rate this service because this was a focused inspection.

We found:

- The provider had identified that they were not able to meet the care needs of three patients with very complex problems and behaviours that staff found challenging. For all three, the provider had worked actively to facilitate discharge without success. In one of these cases, the patient had been subject to repeated and prolonged periods of seclusion and segregation for about 18 months before the inspection visit. The staff at St Andrew's had decided that this was necessary to reduce risk to the patient concerned, to other patients and to staff.
- We found one example where staff had not worked with a patient in the least restrictive way. They had applied restrictions despite the patient demonstrating reduced risk behaviours. Staff justified this based on the historic risks of the patient as opposed to the patient's current presentation.
- There were gaps in some observation records; one example being staff not recording hourly checks in two records. Staff also recorded one patient's behaviour as being settled for sustained periods of time, without ending seclusion as required by the Mental Health Act Code of Practice.
- The provider had not facilitated independent reviews of patients' in long term segregation in line with the Mental Health Act Code of Practice which states that 'where long-term segregation continues for three months or longer, regular three-monthly reviews of the patient's circumstances and care should be undertaken by an external hospital'. Staff employed by St Andrews had carried out the 'independent reviews' of patients in long-term segregation on these wards. Although these staff members worked in a different St Andrew's hospital, or were from a different service on the same site, in CQC's view this is not consistent with the intention of the Mental Health Act Code of Practice.
- During the three months between 31 July 2018 and 31 October 2018, the service had recorded 57 incidents of staff injury. These included staff being punched, kicked, scratched and pushed to the floor and being

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stamped upon. During one incident, five different staff had to attend the local accident and emergency department for injuries to the face, head and abdomen.
- Some staff did not feel that the provider gave consistent support after incidents and that managers delivered de-briefs for 'significant' issues only. This affected their morale, particularly when incidents related to staff assaults.
- Four carers reported that staff had not informed them of incidents involving the person they cared for in a timely way. One carer told us that the provider did not offer them a de-brief after they had witnessed an incident involving their relative.
- Staffing levels and skill mix had sometimes contributed to the cancellation of planned activities.

However:

- Staff worked actively to protect patients from avoidable harm. They assessed patient risk and updated risk assessments regularly and following incidents. Staff conducted observations of patients in line with their care plans. Staff used de-escalation and distraction techniques to reduce the need to use physical restraint.
- Staff recorded the clinical justification for placing restrictions, for example, seclusion and long term segregation, on patients and made decisions based on the assessed risk to the patient, risk to other patients and risk to staff. Staff developed positive behaviour support plans and those who worked directly with the patients were aware of the contents of these plans and these directed the interventions used to care for patients.
- In eight out of nine cases that we reviewed, staff worked in collaboration with the patient concerned to reduce restrictions at the earliest opportunity.
- The care and treatment interventions provided by staff were in line with best practice and evidence based guidance. Care plans reflected the holistic needs of the patient. The service employed a range of staff to work with patients to meet their needs including occupational therapists, teaching staff and clinical psychologists. Staff of all disciplines regularly tried to engage patients in education, therapy sessions and activities. Staff recorded the outcomes of sessions or if the patients declined to take part.
- Patients told us that staff generally treated them with respect. Patients were involved actively in developing their care plans and knew their content. Those patients being cared for in seclusion or segregation had access to and understood their re-integration plans. All patients knew of the advocacy service and how they could access this should they need to. Staff displayed knowledge of individual patient need and the goals patients were working towards.
- Staff encouraged patients to keep in contact with people important to them. This took place via face to face visits or via telephone or video conferencing.
- The service provided premises appropriate to the age of the patient group. Staff encouraged patients to personalise their space. This included patients who were in long-term segregation. Staff encouraged patients to engage with sessions and activities when in seclusion and long-term segregation to continue to work towards their individual treatment goals.

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Background to St Andrew's Healthcare - Adolescents Service

St Andrew's Healthcare Northampton has been registered with the CQC since 11 April 2011. The service has a registered manager and a controlled drug accountable officer. The registered locations at Northampton are adolescent services, men's services, women's services and acquired brain injury (neuropsychiatry) services.

The hospital site in Northampton is large and consists of more than ten buildings with more than 50 wards and 659 beds.

St Andrew's Healthcare also have services in Birmingham, Nottinghamshire and Essex.

The locations at St Andrew's Healthcare Northampton have been inspected 20 times. The last inspection of the Adolescents service was in May 2017.

We visited the following services during this inspection:

Child and adolescent mental health wards

Wards for children and adolescents with learning disabilities or autism

The adolescents service provides accommodation for patients under the age of 18 years. We inspected the following wards:

- Maple ward is ten bed low secure service for girls under 18 years, who have complex mental health and rehabilitation needs.
- Brook ward is ten bed low secure service for boys under 18 years, who have learning disability and / or neurodevelopmental disability, who present with autism and / or mental health difficulties and / or challenging behaviours.
- Fern ward is a ten-bed low secure service for girls under 18 years with learning disability and / or autistic spectrum disorder and challenging behaviours.
- Bracken ward is a ten-bed medium secure service for boys under 18 years who have learning disabilities and / or autistic spectrum conditions.
- Acorn ward is a ten-bed medium secure service for boys under 18 years who have developmental disability and / or autism.
- Meadow ward is a ten-bed low secure service for girls under 18 years who have complex mental health needs.

All the wards are within one building named Fitzroy, which was purpose built and opened to admissions in January 2017. The building offers a sensory room, music and arts rooms, a sports hall, gardening areas and outside space (courtyards). The service offers education opportunities through St Andrew's college. This college is Ofsted registered and rated as outstanding.

This inspection was a focused inspection and unannounced. The inspection took place over a total of four days across a three-month timeframe. This was because the inspection team revisited the hospital following receipt of new information.

Our inspection team

Team leader: Victoria Green

The team that inspected the service comprised of three CQC inspectors, a Mental Health Act reviewer and a specialist advisor with experience in the care and treatment of young people with autism, learning disabilities and challenging behaviour.

Why we carried out this inspection

We carried out this unannounced inspection, following a significant concern about the care and treatment of an

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individual, who staff were nursing in long-term segregation, on one of the mental health wards. We reviewed various cases where the provider had placed restrictions, for example, seclusion or long term segregation, on patients.

How we carried out this inspection

We have reported on some of each key question – safe, effective, caring, responsive and well led. As this was a focused inspection, we looked at specific key lines of enquiries in line with concerning information received. Therefore, our report does not include all the headings and information usually found in a comprehensive report.

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

During the inspection visit, the inspection team:

- visited six of the eight wards at the hospital, looked at the quality of the ward environments, including the seclusion and segregation areas
- spoke with 12 patients who were using the service, two of these were in long-term segregation or seclusion
- spoke with the Service Director, who was also the registered manager
- spoke with 30 other staff members; including doctors, nurses, occupational therapist, psychologist, ward managers, clinical team leaders, social workers and health care assistants
- received feedback about the service from a commissioner
- attended and observed one multi-disciplinary team meeting
- attended and observed two community meetings
- examined in detail, the care and treatment records of nine patients, including incident forms and associated seclusion or segregation documentation
- spoke with six carers of young people who were using the service
- undertook five separate episodes of formal observations to see how staff were interacting with patients and meeting their needs (amounting to a total period of two hours and fifty minutes)
- observed CCTV footage to see how staff managed and responded to incidents
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with twelve patients individually. Two of these patients were in long-term segregation or seclusion. The remaining ten were on the wards. Ten out of the twelve patients told us that staff were kind to them, helpful and supportive.

All patients told us that they could keep in touch with family and friends, via telephone, video conferencing, or planned visits, should they wish.

Two patients told us that they felt unsafe on the wards, due to other patients. Two further patients told us that they “sometimes” felt unsafe, particularly when incidents occurred.

Patients told us that staff explained why they were in hospital, and explained their rights to them.

Patients told us they had access to advocacy, and some of the patients had used this service. Those who had not, were aware of it, and knew how they could access.

One patient told us that staff were trying to find them a befriender.

Patients told us that they had access to activities, although did not always choose to attend. One patient told us about attending college, which they enjoyed.

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Two patients told us they knew they could not have access to certain areas or objects because staff had explained this was to support them to reduce their risks. They knew how they could work with staff to change this. For example, some patients had restrictions in place around having supervised access to pens. Staff had based this decision following recent incidents whereby the patients had used pens to harm themselves.

Four out of the twelve patients felt that staff were very busy, or were moved to other wards to support. This had resulted in staff having to cancel or postpone planned activities, such as escorted leave.

We also spoke with six carers about the care of five young people who were using the service (we spoke with two family members of one young person). We spoke with one carer of one of the young people in long-term segregation and two carers of the other young person in long-term segregation. The remaining three were carers of patients being cared for on the open wards.

Four carers told us that the staff were kind and caring and felt that their relatives received good care. Two carers expressed concerns regarding how up to date they were kept with their loved one's care and felt that not all staff knew the details about how their loved one should be cared for.

Four carers described delays in finding out about incidents that their relatives had been involved in.

Four carers were happy with the hospital facilities, activities on offer, treatment and education. Two carers told us that the person they cared for had not had access to the treatment described by the provider prior to their admission. This included examples, such as, access to anger management programmes.

Two carers gave us examples of when staff did not facilitate planned activities for their relatives, due to staffing issues.

One carer told us that the provider did not offer them a de-brief after they had witnessed an incident involving their relative.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found:

- The layouts of the wards enabled staff to have a clear view of communal areas. There was a staff presence across all the wards visited. Patients who needed enhanced observations for safety reasons, had staff members with them. All staff and visitors had personal alarms, so that they could summon help if needed.
- Staff completed a risk assessment of every patient upon admission, and updated these regularly. The staff teams responded to any changes in risks of patients and put care plans in place to manage these. Staff escalated safeguarding concerns appropriately, and included relevant information in care records.
- Staff placed restrictions on patients. In most instances that we reviewed, these appeared to be justified based on clinical assessment that such restrictions were necessary to protect the individual concerned and/or to protect other patients and/or to protect staff. Staff discussed restrictions with the patients concerned. They explained the rationale, and worked with the patients to reduce the level of restriction. We concluded that staff used restraint only after using other techniques which did not prove successful. However, one care record showed that staff had applied restrictions based on a presumption, due to previous incidents, that a patient's risk would increase and not on the patient's current presentation. This led to staff secluding a patient following a day of risk free behaviour.
- Ward managers informed staff of any expected admissions. This included information about the patient's presentation, as well as both historic and present risks. Staff discussed an initial plan of care and staff introduced a positive behavioural support plan at the earliest opportunity.
- Staff reported incidents in line with the service policy. The multi-disciplinary team reviewed incidents weekly during patient reviews. The service had support systems in place for staff following incidents.

However:

- Low staffing numbers had an adverse impact on patients. On occasions, staff had cancelled patients' planned activities, due

to staffing difficulties. In one example, over a period of six weeks, the provider was unable to meet the prescribed staffing levels for a patient and was not able to provide a regular core team of staff, to meet the individual's needs.

- There were some gaps in the documentation that recorded staff's engagement with patients nursed in seclusion or long-term segregation. We sampled two patient's records; in one we found that 26% of planned contacts had not been recorded over a six-week period and in the other 16% of planned contacts had not been recorded over a one-month period. Although staff recorded daily entries in the clinical notes, the provider's policy stated that these should have recorded on an hourly basis. On one occasion, we noted that staff had used incorrect terminology in care records - referring to "long-term seclusion".
- During the three months between 31 July 2018 and 31 October 2018, the service had recorded 57 incidents of staff injury. These included staff being punched, kicked, scratched and pushed to the floor and being stamped upon. During one incident, five different staff had to attend the local accident and emergency department for injuries to the face, head and abdomen.
- Although the provider had systems in place to support staff affected by adverse incidents, some staff we spoke with reported that these were not always available. Bank and agency staff were not sure if they could access support in the same way that permanent staff could. Not all staff felt supported by managers after being involved in incidents of violence and aggression.

Are services effective?

We found:

- Staff created care plans that were personalised, holistic, and looked forward to recovery based goals. Staff updated and reviewed these regularly.
- Staff used positive behavioural support (PBS) to work with patients to reduce the occurrence, severity and impact of their behaviours. Staff used PBS to understand the meanings of behaviours for individuals and to develop the most supportive environment. Staff included information specific to patients' diagnosis in PBS plans and adapted strategies based on how the diagnosis may affect the patients' engagement and presentation.

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- The multi-disciplinary team provided a range of care and treatment interventions appropriate to the patient group. Interventions included those recommended by the National Institute for Health and Care Excellence.
- The service had a range of specialists to meet patient needs holistically. Staff had various experience and relevant qualifications to meet the needs of the patient group.
- Staff met patients' physical healthcare needs. Staff placed emphasis upon the wellbeing of patients, which was clear in care records viewed.

Are services caring?

We found:

- Patients and carers told us that staff were kind, caring and supportive. Staff had a good rapport with patients, and offered emotional support when needed. We saw healthcare assistants actively engaging with patients through ward based activities.
- Most patients knew what information their care plans and positive behavioural support plans contained. Staff had offered them a copy. Staff tailored styles of communication to individual patient need.
- All patients maintained regular contact with family, if they wished. This was regardless of where the patients were cared for (on the ward, in seclusion, or in long-term segregation).
- Staff supported patients to access the advocacy service, if needed. Staff also sought out befrienders, if the patients felt that this would benefit them.

However:

- Four carers told us that staff had not informed them of incidents involving their relatives in a timely way, which they felt was disappointing.

Are services responsive?

We found:

- The service had identified that because of the patients' complex needs and presentation that a hospital environment was not the most appropriate care model for them, and they would benefit from a specialist package of care, with access to specially trained staff. Whilst the provider had taken appropriate steps to highlight this to the wider mental health system, some patients experienced a delay in discharge to

more suitable services. Staff continued to care for patients despite not having the appropriate facilities to do so. This contributed to increased restrictions, for example, seclusion or long term segregation, to keep patients safe.

However:

- Patients could personalise their personal space / bedrooms. Each patient had their own bedroom with en-suite facilities.
- Staff and patients had access to a full range of rooms and equipment to support the care and treatment of patients. The provider ensured staff worked with patients regularly. Staff did this to ensure they were familiar with the individual needs of the patients and to avoid increasing the anxiety of the patients.
- Staff supported patients to keep contact with family and carers. Patients could make a telephone call in private. Video conferencing was also available.
- The multi-disciplinary team ensured that educational programmes, and an activity timetable was available to all patients.

Are services well-led?

We found:

- The provider had not facilitated independent reviews of patient's in long term segregation in line with the Mental Health Act Code of Practice which states that 'where long-term segregation continues for three months or longer, regular three-monthly reviews of the patient's circumstances and care should be undertaken by an external hospital'. Staff employed by St Andrews had carried out the 'independent reviews' of patients in long-term segregation on these wards. Although these staff members worked in a different St Andrew's hospital, or were from a different service on the same site, in CQC's view this is not consistent with the intention of the Mental Health Act Code of Practice.
- Some staff did not feel the provider gave consistent support after incidents and that managers delivered de-briefs for 'significant' issues only. This affected their morale and attendance at work, particularly when incidents related to staff assaults.
- Although the provider was able to staff wards at a level they had assessed as being safe, at times there were too few staff to meet all care needs.
- In complex cases, there was a lack of clarity about what restrictions staff placed on patients and the appropriate safeguards and policies that applied.

However:

Summary of this inspection

- All staff interviewed were passionate about their roles, and motivated by wanting to do the best they could for the patients.
- Ward managers and the ward teams offered support to one another, on an informal basis each shift, within formal supervision and as and when needed.
- The service held monthly care awards, with quarterly winners that fed into the provider's annual care awards event. Staff could nominate colleagues for one of these awards, based on the providers values.

Child and adolescent mental health wards

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are child and adolescent mental health wards safe?

Safe and clean environment

- The layout of the wards enabled staff to observe all parts of the ward effectively. Staff were present in the main communal areas. Staff observed patients based on the clinical decision made by the multi-disciplinary team (MDT). The MDT prescribed observation levels based on risk to keep individuals and other patients safe.
- The wards complied with guidance on eliminating mixed-sex accommodation.
- All staff and visitors carried personal alarms, so that they help could summon help if needed.
- All wards were clean, had appropriate furnishings and were well maintained. Fitzroy provided an environment suitable for the age of the patients.

Safe staffing

- The provider frequently used bank and agency staff to cover sickness and absence. We saw that some bank and agency staff worked regularly within the service, to help continuity of care.
- We examined the rotas of wards visited between 01 July 2018 and 20 September 2018. We found that all wards maintained safe staffing numbers, in line with the agreed staffing. However, we also found that during this time, 46 staff members had been moved from one ward to assist on another, for part, or the entire shift. This could have impacted upon planned activities with patients. Four patients told us that this had happened on occasions. In addition, one carer told us that staff had cancelled their relative's escorted home leave due to staffing shortages. Another carer talked about the hospital having good facilities, but not always having the staff available so that their relative could use these.
- In one case, the provider did not ensure that they met the staffing levels required to support a patient with complex needs for 127 hours out of a total of 1568 hours. Also, they did not always ensure that the staff team working with that patient had the ratio of male to female staff that the care plan stated was ideal to minimise the patient's anxiety nor did it include a sufficient number of staff who knew the patient well. We concluded this by reviewing the staff rotas for the care of this patient over a period of six weeks from 3 December 2018 to 13 January 2019.

Assessing and managing risk to patients and staff

- Staff completed a risk assessment of every patient upon admission, and updated these regularly. Staff used the provider's comprehensive risk assessment tool. Staff considered historical and current risk information to determine how best to care for patients.
- The multi-disciplinary team identified and responded swiftly to changing risks of patients. The team met to discuss the clinical presentation of individual patients if there appeared to be a new perceived risk, or change in behaviours. This included meetings that took place outside of hand overs and routine multi-disciplinary meetings. Staff reflected these discussions in each patient's positive behaviour support plan. These plans were available to staff electronically, and in paper form in each ward office. The plans were personalised and in easy read versions for patients, if needed. This was particularly useful for bank and agency staff, if they had not worked on the wards for some time.
- In most records that we reviewed, staff had only secluded or segregated patients' following a comprehensive risk assessment. Staff secluded or segregated patients for reasons such as: physical aggression towards other patients and staff, to protect dignity and to protect the safety of person concerned, other patients and staff. We reviewed one incident

recorded on a closed-circuit television which resulted in a patient's seclusion. Seclusion resulted due to a severe behavioural disturbance which caused harm to others. One patient, who staff were nursing in a seclusion room at the start of the inspection, had been moved to the extra care suite to be nursed in long term segregation by the end of the inspection. The extra care suite consisted of a bedroom, day area, bathroom and an area with access to fresh air.

- Staff undertook regular reviews of whether restrictions, such as seclusion and long term segregation, should continue. In most records, staff had justified the continued use of seclusion or long-term segregation on clinical grounds. However, in one record, staff secluded a patient following a day of minimal risk behaviour. The decision to do so was based on a presumption, due to previous incidents, that the patient's risk would increase, rather than patient's current presentation. In the same record there were examples of staff not terminating the seclusion despite recording that the patient's behaviour was settled. Across a period of 18 days there were 285 entries relating to their seclusion. In 93% of entries staff recorded the patient's behaviour as 'settled' or 'asleep'. Seven percent of entries described increased risk behaviours.
- The environments we saw met the requirements of the Code of Practice in relation to the personalisation of areas. Some areas where staff nursed patients were more personalised than others, but this was individual patient choice. Every patient had a re-integration plan in place, where appropriate. These plans outlined the expectations of the patients, so that staff could end the periods of seclusion / long term segregation. Staff explained these to patients to ensure understanding. Staff facilitated access to therapeutic interventions and activities, dependent upon level of risks. We saw examples of patients using art and craft material in seclusion when it was safe to do so.
- Staff kept individual records of seclusion for each patient but some staff had not always recorded information relating to interactions and activities for each period allocated. We looked at one patient's records, which equated to 816 hours of care. Staff had failed to enter interactions or record what the patient was doing on 128 occasions (128 hours or 16% of the expected total number of recordings). In another record, staff failed to record 26% of observations required. Staff recorded daily entries in the clinical notes. However, staff, in line with policy, should have recorded on an hourly basis. There was one instance where staff had not used the correct terminology in a patient's records. They referred to the restriction applied as being "long-term seclusion". In one record there was a lack of clarity about what restrictions staff placed on patients, for example, describing the seclusion of a patient as long term segregation and the appropriate safeguards and policies that applied.
- The service provided data concerning staff assaults over the past three months (31 July 2018 to 31 October 2018), across the six wards visited. There had been 57 staff injuries. These included staff being punched, kicked, scratched and pushed to the floor and being stamped upon. During one incident, five different staff had to attend the local accident and emergency department for injuries to the face, head and abdomen. Four staff that we spoke with who had experienced physical assaults from patients, did not feel supported by senior staff. One staff member claimed they "were used to it", and a further staff member stated that "being hit was viewed as part of the job – you just have to get on with it".

Safeguarding

- Staff made referrals to the local safeguarding team as and when necessary. Staff reflected this in care records, care plans, risk assessments and multi-disciplinary reviews.

Staff access to essential information

- Managers gave staff on the wards a comprehensive handover of new patients admitted. All staff we spoke with told us that managers gave information verbally following the initial assessment, and through documentation. This included previous and current risk assessments, care plans and positive behavioural support plans, if staff had developed these.
- The provider used an electronic recording system which all staff could access. If a patient transferred between wards or teams, the electronic system held all the information the receiving team would require to effectively care for the patients.

Reporting incidents and learning from when things go wrong

Child and adolescent mental health wards

- All staff that we interviewed understood what incidents should be reported and we concluded that staff reported incidents appropriately.
- Staff we spoke with told us that there were support systems in place for staff following incidents. These included formal de-briefs, support offered during supervision, reflective practice and sessions with a trauma specialist within the service. However, some staff felt that managers and senior staff did not fully acknowledge the stress of what they termed "day to day assaults". Bank and agency staff were not sure if they could access support in the same way that permanent staff could. The provider informed us that bank staff received the same training and support as permanent staff and that they would provide support initially to agency staff but ongoing support was the responsibility of the agency provider. Staff told us that managers offered de-briefs following significant incidents, where staff or patients had experienced significant injury, but not routinely after every incident. The data provided showed six formal de-briefs had been recorded. In addition, the service had offered de-briefs through reflective practice but staff did not record these. The provider told us that they planned to launch a zero tolerance to verbal and physical assault campaign.
- Four of the six carers we spoke with, told us that staff had not always informed them in a prompt way when their relatives had been involved in an incident. One carer told us that the provider did not offer them a de-brief after they had witnessed an incident involving their relative.

Are child and adolescent mental health wards effective?
(for example, treatment is effective)

Assessment of needs and planning of care

- We examined nine care records. Care plans were personalised, holistic and recovery orientated. Staff updated care plans as and when needed, involving the patients where possible.

Best practice in treatment and care

- The multi-disciplinary team provided a range of care and treatment. Examples we saw of these included dialectical behaviour therapy (DBT); cognitive behavioural therapy (CBT); offence related work; family interventions and medication optimisation. The service also offered education and training; hospital based and external leisure activities, and the promotion of independence around self-care.
- Staff used positive behavioural support (PBS) to work with patients to reduce the occurrence, severity and impact of their behaviours. PBS is a person-centred framework for providing long-term support to people with a learning disability and/or autism, including those with mental health conditions, who may have, or may be at risk of developing, behaviours which challenge. Staff used PBS to understand the meanings of behaviours for individuals and to develop the most supportive environment. Staff included information specific to patient's diagnosis in PBS plans and adapted strategies based on how the diagnosis may affect the patient's engagement and presentation.
- Staff ensured that patients had good access to physical healthcare, by attending appointments with healthcare professionals, or facilitating visits to the general hospital where required. Staff followed advice of healthcare professionals to ensure patients received the appropriate care following discharge from general hospitals.
- Staff placed emphasis upon the patients' wellbeing, which they demonstrated in care plans. Examples seen related to self-care, weight management, and sports and exercise. Staff ensured they monitored physical health issues, such as weight and recorded this appropriately in patient notes.
- Four carers spoke about their relatives having specific physical health needs. Two felt assured that staff were meeting these needs. However, two carers raised concerns that staff were not always meeting their relative's physical health needs.

Skilled staff to deliver care

- The service employed a range of specialists with the experience and skills to meet the needs of most of the patients. The team included doctors, nurses, healthcare assistants, clinical psychologists, psychology assistants, occupational therapists, technical instructors, social workers, teachers, dieticians and speech and language therapists.

- The provider had concluded that the existing staff team did not have the skills required to meet the complex needs of one patient. This led to managers arranging specialist training for staff in December 2018.
- All staff within the service received training in positive behavioural support planning. In addition to this, the psychologists also discussed individual patients at length during reflective practise sessions. This gave staff the opportunity to try to understand the patients' behaviour and how best to support them.

Multi-disciplinary and inter-agency team work

- The multi-disciplinary team met once a week to discuss individual patients care and treatment.
- In records we reviewed, we saw an example of a positive working relationship with a commissioner who had patients placed in the service.
- We observed a member of the multi-disciplinary team visit a ward specifically to discuss a safeguarding concern which had arisen between two patients.

Are child and adolescent mental health wards caring?

Kindness, privacy, dignity, respect, compassion and support

- We observed numerous interactions between staff and patients, across the six wards visited. Most staff had a good rapport with the patients, and were chatting easily with them. We saw staff offer emotional support when needed. One example being that staff reassured a patient who was anxious about going into a meeting. We also saw that staff were responsive to needs, for example when patients requested a drink or a chat. We saw healthcare assistants taking part in activities with patients. Examples were playing cards, plaiting hair, and playing with a ball in the courtyard.
- Most patients described the staff as kind, helpful and supportive. Four carers told us that the staff were kind and caring, and provided good care for their relatives. One carer told us that staff did not communicate with them.
- Staff directed and supported patients with accessing the advocacy service, where needed. We also found staff actively seeking out befrienders for some patients, who felt they would benefit from this.
- Staff interviewed, including bank and agency staff, had a good understanding of individual patient needs. It was clear that staff were familiar with the positive behavioural support plans, and knew what worked for each patient at times of distress.

Involvement in care

- Staff had an admission process which helped orientate new patients to the wards. Where possible, staff followed this to welcome new admissions to the allocated ward and to the hospital.
- Patients we spoke with were aware of their care plans and positive behavioural support plans. Not all patients agreed with all the content of care plans. However, they understood why they were in place, and knew the multi-disciplinary team would review the plans with them and make changes accordingly. Patients could have copies of care plans if they wished.
- Staff considered the best way to communicate with patients. Care plans and positive behavioural support plans showed this. Patients also has communication passports where appropriate.
- All patients had regular contact with family if they wanted. Staff facilitated visits, patients could use the telephone, and some patients used video conferencing. This included patients who staff were nursing in long-term segregation or seclusion, if assessed to be safe and appropriate. Carers we spoke with confirmed this.
- Four carers we spoke with were aware of the carers group.

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

Access and discharge

- Managers told us that the hospital was not a suitable environment for the ongoing care of three of the patients on the wards at the time of the inspection. The managers' opinion was that these patients would be better served by a community placement with very intensive support. For two of these patients, this was because the patients were ready to leave hospital. For the third patient, managers had concluded both that the hospital was not a suitable environment and that

the staff team did not have the skills required to meet their complex needs. We examined the care records of these three patients. In the first example, the service had made active and repeated attempts to support the discharge of the patient to a more suitable setting since December 2017. Records showed ten different meetings to support this. These included meetings with case managers and clinical commissioning groups, patient assessments, a case conference and a care and treatment review. The team had explored both alternative hospital placements, as well as a bespoke service in the community. The records of the second patient showed that, since a planned bespoke package of care had been withdrawn early in 2018, the service had recorded eight different contacts with professionals and teams that might provide aftercare. These included discussions with case managers, different patient assessments, a request for independent review, and a care and treatment review. Staff continued to explore both hospital, and bespoke community placements. The care records for the third patient showed fourteen different contacts regarding discharge, since June 2018. These included different patient assessments, meetings with case managers, a Mental Health Tribunal meeting, a care and treatment review and various contact with potential placements. We concluded that the provider had made reasonable efforts to discharge these three patients but had been unable to facilitate this due to issues with lack of suitable placements in the community and difficulties with securing funding for placements.

The facilities promote recovery, comfort, dignity and confidentiality

- All patients had their own bedroom with en-suite facilities.
- Patients personalised their bedrooms. Patients in long-term segregation had also personalised their living space.
- The hospital and the wards had access to a range of rooms and equipment to support care and treatment. Each ward had access to fresh air, an activity room, clinic room and therapy / meeting rooms.
- The hospital had designated areas for family visiting. Staff facilitated visits from families to seclusion and long-term segregation areas if patients were not able to leave the ward.
- Each ward had a phone booth, as well as a hand-held phone which patients could use in quiet rooms. Staff supervised some patients using the telephone due to risk. Staff had clearly documented this in the patient's risk assessment and care plan, which gave a clinical justification for the supervision at that time. If staff assessed patients as safe to do so, they could make phone calls in private.
- Four carers we spoke with were happy with activities, hospital facilities and the educational input available. One carer told us that access to activities and therapies was dependent on the staff available.
- The service offered educational programmes and activities. We noted that at the time of our inspection, some patients were undertaking GCSE examinations.

Are child and adolescent mental health wards well-led?

Leadership

- The provider had not facilitated independent reviews of patient's in long term segregation in line with the Mental Health Act Code of Practice which states that 'where long-term segregation continues for three months or longer, regular three-monthly reviews of the patient's circumstances and care should be undertaken by an external hospital'. Staff employed by St Andrews had carried out the 'independent reviews' of patients in long-term segregation on these wards. Although these staff members worked in a different St Andrew's hospital, or were from a different service on the same site, in CQC's view this is not consistent with the intention of the Mental Health Act Code of Practice.
- Senior staff acknowledged that some staff within this service had been seriously assaulted, which caused stress, and had led to some sickness. Over the three-month period prior to inspection, there had been 57 reported staff injuries across the six wards. Staff had been subjected to being punched, kicked, scratched, pushed over and stamped upon. During one incident, five staff had to attend the local accident and emergency department for treatment of facial, head, and abdominal injuries.
- Although the provider was able to staff wards at a level they had assessed as being safe, at times there were too few staff to meet all care needs.

- In complex cases, there was a lack of clarity about what restrictions staff placed on patients and the appropriate safeguards and policies that applied.
- Staff on the wards spoke highly of the support offered on a day to day basis by peers and the ward managers.

Vision and strategy

- Staff we interviewed all spoke about the ethos of the wards they worked on. The common themes were to provide individualised care, to support the patients in any way they could, and to work towards discharging patients into the community, or to a less restrictive environment where possible.

Culture

- Staff did not feel the provider gave consistent support after incidents and that managers delivered de-briefs for 'significant' issues only. This affected staff morale and attendance at work, particularly when incidents related to staff assaults.
- Not all staff interviewed felt supported and valued for the work they did. However, despite this, those interviewed continued to do their best for the patients they were caring for, and clearly enjoyed their role and the positive contribution they made to the patients' lives.
- Nurses and healthcare assistants spoke about the ward teams being very supportive of one another, and said they could talk to their peers if they felt stressed by incidents at work, on an informal basis.
- The service held monthly care awards, with quarterly winners that fed into the provider's annual care awards event. Staff could nominate colleagues for one of these awards, based on the providers values.

Outstanding practice and areas for improvement

Outstanding practice

We saw an example of a visual support plan that informed staff of the physical distance staff needed to be from a patient to best meet their needs. Staff could easily see the distance required, between themselves and the patient, depending upon what activities the patient was engaged in, and where the patient was. This was to maintain as much personal space and dignity as possible, while keeping the patient safe.

Areas for improvement

Action the provider MUST take to improve

- The provider must take every reasonable step to ensure that, for patients in long term segregation, the regular three monthly reviews of the patient's circumstances and care are undertaken by a suitably experienced, senior professional from a different provider.

Action the provider SHOULD take to improve

- The provider should ensure that staff follow the Mental Health Act Code of Practice when applying restrictive interventions, such as seclusion and long term segregation.
- The provider should ensure that seclusion and long-term segregation paperwork is completed in full.
- The provider should ensure patients are not secluded for longer than required.
- The provider should ensure sufficient staff of the right skill mix and gender are available to support patients.
- The provider should ensure that carers are updated in a timely manner regarding their relatives care and treatment, including incidents.
- The provider should ensure that all staff have access to appropriate support following incidents.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The provider had not facilitated independent reviews of patient's in long term segregation in line with the Mental Health Act Code of Practice which states that 'where long-term segregation continues for three months or longer, regular three-monthly reviews of the patient's circumstances and care should be undertaken by an external hospital'. Staff employed by St Andrews had carried out the 'independent reviews' of patients in long-term segregation on these wards. Although these staff members worked in a different St Andrew's hospital, or were from a different service on the same site, in CQC's view this is not consistent with the intention of the Mental Health Act Code of Practice.