Requires Improvement

Leeds and York Partnership NHS Foundation Trust

Child and adolescent mental health services

Quality Report

Lime Trees Child, Adolescent and Family Unit
Tel: 0113 305 5000
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Date of inspection visit: 30 September – 1 October 2014
Date of publication: 16 January 2015

Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
Lime Trees Child, Adolescent and Family Unit	RGDX8	Lime Trees Child, Adolescent and Family Unit	YO30 5RE

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

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

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

Summary of findings

Ratings

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

Overall rating for 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?	**Good** 
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.

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Overall summary

The Lime Trees child, adolescent and family unit provides 24 hour inpatient psychiatric care to nine young people, male and female, who are between the ages of 12 and 18 years old. The service provides care to young people who are suffering from, or believed to be experiencing, a mental health problem. Although many of the young people being cared for within the unit are from the local geographical area, the unit also provides care to young people nationally.

The unit consists of three terraced properties which had been converted to make one larger building. The trust had plans for the service to be re-located, by the end of 2014, to provide a more modern care environment.

The unit was last inspected by the Care Quality Commission (CQC) in December 2013. At that inspection, we identified concerns with regards to the unit's premises and also in relation to how the service assessed and monitored the quality of the services provided. We had concerns regarding the number of ligature risks in the unit and found the unit was not fully compliant with equality legislation in terms of disability access.

Following that inspection we issued compliance actions against the trust as a means of ensuring standards were improved. The trust prepared an action plan to rectify the issues of concern.

Mental Health Act commissioners (now known as Mental Health Act reviewers) from the CQC, attended the unit on 23 June 2014 to review how the unit was managing young people who had been detained under the Mental Health Act 1983 (MHA). Mental Health Act commissioners had concerns regarding the lack of ventilation, the bedrooms of males and females being on the same corridor, detained young people not always being given information about their detention, and the narrowness of the unit's corridors.

This inspection included checks to make sure our previous concerns had been addressed.

Summary of findings

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

Are services safe?

Requires Improvement

Whilst we saw care records were in place, and were being used by staff, there was also evidence of some gaps in children's/young people's observation records. Some of these gaps were of a significant duration. On balance, however, we concluded these gaps were indicative of a lack of record keeping as opposed to staff not carrying out observations in accordance with care plans.

Following on from the previous CQC inspection, improvements had been made with regards to the environment's safety and management of potential risks. Examples of such improvements included sealing potential ligature points and installing collapsible rails. Despite these improvements, there were a minority of doors whose closing mechanisms could present as a ligature risk. These doors, however, were in areas where staff would be present which meant the risks to children and young people were reduced and able to be managed. We saw risk assessments had been carried out by the trust to identify where potential hazards were located in the unit; whilst many of the potential hazards had been identified and plans put in place to reduce such risks, not all of the door closing mechanisms had been identified by staff as part of their own risk assessment process.

Some staff did not know where the oxygen masks, used as part of resuscitation, were kept. These were eventually found after asking different staff and some time delay. We saw that whilst most medication charts had been fully completed, several charts did not record how much children/young people weighed. Given that the doses of some medications can vary depending on a person's weight, this lack of recording presented a potential risk of a child/young person being given the wrong dose of medication.

We noted that all bedrooms were on the same corridor and a lack of separation between male and female sleeping areas risked the privacy and dignity of children and young people not being protected. Unit staff were aware of this risk but gave inconsistent explanations of how this was managed. At the time of our inspection, how these risks were managed was not formally documented. This meant there was a risk that privacy and dignity issues were not being robustly and consistently implemented. The trust responded to this promptly by ensuring a written risk management process was produced and shared with us within a few days of the inspection having taking place.

We found the unit to be both clean and tidy. Access to the unit was controlled by locked doors which required a security number to be

Summary of findings

opened. This security number was known only to staff. Controls on who could access the unit meant children and young people were being protected from others who had no right or reason to be on the premises.

The majority of ward staff who we spoke with were of the opinion that staffing levels on the unit were now sufficient. According to the unit manager and assistant manager, staffing levels on the unit had recently been increased. This increase was in response to the demands being put on staff and to ensure children's/young people's needs were being met. This increased staffing also meant the service was adhering to best practice guidance which had been issued by the Royal College of Psychiatrists regarding safe staffing levels. Should additional staffing be needed, for example at times of staff sickness and enhanced levels of observations being needed, then ward managers were able to authorise, by themselves, the deployment of additional staff. It was the view of the young people we spoke with that staffing levels on the unit were good and that staff were always available if they needed support.

Records we reviewed contained completed risk assessments. In order to identify and appropriately respond to any safeguarding concerns, safeguarding processes for both adults and children were in place. During our interviews with staff, they were able to explain what actions they would take if they had concern about a person's safety and welfare. We saw documentation in one of the care records we reviewed which showed how the unit worked in collaboration with social services in relation to a safeguarding concern.

All of the children/young people who we spoke with, on the unit, felt safe.

Are services effective?

Good

We found care plans had been formulated so that children's/young people's needs were being met. Care plans we reviewed were both up to date and had been reviewed on a regular basis. The care plan reviews had been carried out on a multi-disciplinary basis. We found the physical health needs of young people had not been overlooked and physical health care interventions had taken place. Examples of such interventions included bloods tests being completed, weight monitoring, food intake monitoring and kidney scans.

The unit staff consisted of multi-disciplinary team (MDT) and each child/young person had input from different professionals. Such professionals included occupational therapy, psychology, medical and nursing staff.

Summary of findings

Staff were aware of best practice guidance in relation to child and adolescent mental health, such as NICE guidance and guidance issued by the Royal College of Psychiatrists. Audits were undertaken to examine how the unit adhered to these.

Activities were available for children/young people on the unit. We found a programme of activity for each young person was devised which included education, and other group and one-to-one activities. However, we noted that activities were not scheduled for evenings or weekends. We received negative feedback from several of the children/young people who spoke with us about their activity programmes. Some children/young people said they got bored on the unit and some children/young people felt the activities which were made available to them did not always meet their needs.

Whilst the trust required staff to participate in mandatory training, we found mandatory training for many of the unit's staff was not up to date. To illustrate this, figures provided to us by the trust indicated that the majority of ward staff were not up to date with essential life support training and the majority of unit staff were not up to date with their safeguarding level 3 training.

Some Mental Health Act 1983 (MHA) processes were being appropriately followed. For example, children/young people who had been detained under the MHA were given their rights, as is required by section 132 MHA. However, staff did not always promptly follow the procedure regarding the independent scrutiny of MHA paperwork. These time delays meant there was a risk that the statutory paperwork regarding a child's/young person's detention may not be accurate and complete. There was also a risk that any failure to comply with the procedural requirements of the MHA may not be promptly identified. A shortfall was similarly identified with respect to the unit's compliance with the Mental Capacity Act (MCA). For example, the parents of some young people were being asked to give signed consent for various decisions related to the young people's care even though there is a general presumption in law that young people are deemed to have capacity to make decisions for themselves.

Training in relation to the MCA was not mandatory. This meant there was a risk that decisions taken and carried out for those who lacked mental capacity may not be in line with the law and the requirements of the MCA code of practice. Whilst some staff had received training in relation to the MHA, the training of staff in relation to the MHA was also not mandatory. This meant there were risks that care and interventions, for those who came within the MHA's powers, may not be carried out in accordance with the law.

Summary of findings

Are services caring?

Good

Young people said that most staff were both polite and respectful towards them. Whilst observing care taking place, we saw staff to be both caring and respectful towards the children/young people who were on the ward. We saw children/young people appearing at ease with staff and noted the unit's atmosphere to be calm and settled. Records referring to children/young people were written in a professional and non-judgemental manner, and we saw staff discussing children's/young people's care in the multi-disciplinary team (MDT) meeting in a respectful manner.

Children and young people had an awareness of the care plans which were in place for them and there was evidence of children/young people having been involved in the development of these plans. Parents/carers of children/young people were equally involved and given opportunities to give their views, discuss any concerns and give feedback. In addition to children/young people giving views about their care within the care planning process, ward community meetings were held for children/young people to raise any concerns and express their views.

Children/young people did not routinely attend the MDT meetings where their care was discussed by staff. Children and young people were able to contribute to the MDT discussion, offer their views and express their wishes, however by means of completing a written sheet. This was then read out within the MDT, considered by the MDT and subsequently fed back to the child/young person.

Are services responsive to people's needs?

Requires Improvement

There were some limitations to the building and its environment. For example, we noted that the unit had narrow corridors; we saw people either had to stand back in a door way to let another person pass, or stand aside at an angle as otherwise there was a risk of entering another person's personal space whilst passing on the corridor. A different example was related to window catches having been removed and windows sealed shut as a short term strategy to keep children/young people safe from potential ligature risks. Whilst we received feedback from both staff and children/young regarding a lack of air flow and temperature fluctuations this had caused, the service had taken steps to manage and minimise the impact. For example, fans were made available and a ventilation system had been installed.

The service had a range of rooms and equipment to support the care and treatment of children/young people. For example, there was a private clinic room, a lounge area and conservatory. The unit

Summary of findings

had a large outside area although in order to maintain children's/ young people's safety and ensure monitoring could continue access to this was controlled and supervised by staff. Educational facilities were also on site.

Provision was in place which ensured children and young people were able to maintain contact with family and friends. This included having a stock of mobile telephone phones, which did not have a camera facility so the privacy of others was maintained, and having a cordless telephone which children/young people could take to a private room in order to make phone calls.

Information on a range of issues was made available to children and young people. For example, we saw that when children/young people were admitted to the unit they were given information regarding their rights and how to complain. There was information on one of the corridors regarding how children/young people could access advocacy services and the CQC.

It is important to acknowledge that the service recognised there were challenges of providing optimum inpatient care because of the building's physical constraints. In response to this, the service had reduced the number of children/young children they admitted, to a maximum of nine, to ensure the needs of children/young people on the ward were able to be met. The service was also working closely with commissioners, and other stakeholders, regarding the plan which was already in place for the unit to be relocated elsewhere in December 2014.

Are services well-led?

Requires Improvement

Only half of the staff we spoke with were able to identify the objectives and values of the organisation. We did, however, observe staff to deliver care in a way which was consistent with the organisation's values.

Whilst supervision and annual appraisals took place, they did not occur consistently. At the time of our inspection, however, a plan to ensure supervision took place was being devised by one of the managers.

In order to make sure that the service delivered a safe and good standard of care, a range of audits and checks were carried out. We found, however, that the quality monitoring which was carried out was not always sufiiciently robust. For example, gaps within observation records had not been identified, or addressed, by managers despite gaps having been previously raised with the service during the CQC inspection in December 2013.

There was an absence of administrative support for the unit.

Summary of findings

Staff we spoke with were aware of their responsibilities, what was expected of them and who they were accountable to.

Most staff who we interviewed as part of our inspection felt supported by their colleagues, their management and the trust. However, some staff we spoke with, which consisted of different professional disciplines and different grades, reported feeling stressed from the number of changes they perceived were being introduced within the organisation and the move towards electronic patient records.

The service had participated in a peer-review, as part of the Quality Network for Inpatient CAMHS, so that areas for development could be identified and the quality of service be improved.

Summary of findings

Background to the service

The Lime Trees Child, Adolescent and Family Unit provided 24 hour in-patient psychiatric care to nine young people, male and female, who were between the ages of 12 and 18 years old. The service provided care to young people who were suffering from, or believed to be experiencing, a significant mental health problem. Although many of the young people being cared for within the unit were from the local geographical area, the unit would also provide care to young people from all parts of the country.

The unit consisted of three terraced properties which had been built through to make one larger building. Plans were in place for the service to be re-located, by the end of 2014, to a new location in order to provide a more modern care environment.

The unit was last inspected by the Care Quality Commission in December 2013. Within that inspection, we identified concerns with regards to the unit's premises and also in relation to how the service assessed and monitored the quality of the service if provided. We had particular concerns regarding the number of ligature risks in the unit and found the unit was not fully compliant with equality legislation in terms of disability access.

As a consequence of our concerns, we issued compliance actions against the service as a means of ensuring standards were improved. The trust devised and implemented an action plan to rectify the issues of concern.

Mental Health Act commissioners, from the CQC, also attended the unit on 23 June 2014 to review how the unit was managing young people who had been detained under the Mental Health Act. MHA commissioners were concerned regarding the lack of ventilation, males and females being on the same corridor, detained young people not always being given information about their detention, and the narrowness of the unit's corridors.

This inspection included checks to make sure our previous concerns had been addressed. We found most concerns, which had been identified at our previous inspection, had been rectified although we continued to have concern about the unit's environment.

Our inspection team

The team responsible for inspecting Leeds and York Partnership NHS Foundation Trust was led by:

Chair: Michael Hutt**,** Chief Operating Officer, Cumbria Partnership NHS Foundation Trust

Head of Inspection: Jenny Wilkes, Head of Inspection, Care Quality Commission (CQC)

The team included a CQC mental health inspector, nurse specialist advisor, CQC pharmacist, and an expert by experience (and their supporter); our expert by experience was a young person who had personal experience of using services.

Why we carried out this inspection

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

Summary of findings

How we carried out this inspection

We visited the Lime Trees child, adolescent and family unit on 30 September and 1 October 2014. This inspection was announced.

We attended a multi-disciplinary team (MDT) meeting where we observed the care of two young people being discussed. We reviewed six young peoples' care records and looked at the records of young people who were detained under the Mental Health Act 1983. We spoke with six young people about their views and experiences of care on the ward.

We spoke with six staff members. These included health care assistants, nurses, managers and a consultant psychiatrist. In addition, throughout our inspection, we spoke with several staff members on a more informal basis.

Prior to visiting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew. We also asked the service to provide some additional information to us during the inspection process.

To get to the heart of patients' 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?

What people who use the provider's services say

Young people we spoke with said they felt safe on the ward. They gave positive feedback regarding staffing levels and said staff were always around in case they needed support. The young people we spoke with said most of the ward's staff were respectful towards them.

Young people consistently told us about how uncomfortable the ward was, in particular with regards to its temperature. Most young people said the ward got either too hot or too cold. Some young people were unhappy about the lack of fresh air within the building.

Young people said they could access different activities although some believed the activities on offer were not always appropriate. Several young people described feeling bored whilst on the ward.

Good practice

The ward provided mobile phones to young people. These phones did not have a camera facility on them, but allowed young people to put their own SIM cards in them. This meant young people were able to keep contact with friends and family whilst ensuring the privacy of others on the ward was being protected.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

- The provider must ensure they complete their action plan in relation to the relocation of the service to new premises

Summary of findings

- The provider must take action to ensure children and young people who required inpatient care are cared for in an appropriate environment
- The provider must take action to ensure that all staff receive their mandatory training
- The provider must take steps to ensure all appropriate staff receive training in relation to the Mental Capacity Act and Mental Health Act
- The provider must take action to ensure that all records, including medication charts, observation records and records of Gillick competency and mental capacity assessments which are carried out, are always completed and fully documented

Action the provider SHOULD take to improve

- The provider should ensure all unit staff are aware of where all resuscitation equipment and accessories are located
- The provider should carry out a risk assessment in relation to the free standing wardrobes within young people's bedrooms
- The provider should take steps to ensure that independent scrutiny of Mental Health Act documentation takes places in a timely manner

Leeds and York Partnership NHS Foundation Trust

Child and adolescent mental health services

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Lime Trees Child, Adolescent and Family Unit	Lime Trees Child, Adolescent and Family Unit

Mental Health Act responsibilities

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

Young people, detained under the Mental Health Act (MHA) at the time of our inspection, had been advised of their legal rights.

Staff told us they had separate folders where the legal paperwork, which related to a young person's detention under the MHA, was kept. We looked at one of these folders and found that a copy of the MHA assessment carried out by the approved mental health professional (AMHP) was absent. We asked staff about this and they also could not locate it.

We had concern about how long it took for the legal paperwork, relating to young people's detention under the MHA, to be independently checked. In one young person's case the detention paperwork was not scrutinised until 13 days after the date of the young person's detention. In another young person's case the statutory paperwork was not medically scrutinised until 8 days after their detention. These time delays meant there was a risk that the statutory paperwork regarding a child's/young person's detention may not be accurate and complete. There was also a risk that any failure to comply with the procedural requirements of the MHA may not be promptly identified.

Training of staff in relation to the MHA was not compulsory which meant there were risks that the care and treatment of children and young people who came within the Act's powers may not be carried out in accordance with the law.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

We found shortfalls in respect of both mental capacity and Gillick competence issues (Gillick competency being a term used to describe when children under the age of 16 are able to make certain decisions for themselves). Care records showed that parents had been asked to sign and give consent for certain decisions even though there is a general presumption in law that young people aged 16-17 are deemed to have capacity to make decisions for themselves. For example, the parents of a 17 year old young person had completed and signed consent for urgent medical and surgical treatments which might be needed, and for the young person to participate in certain activities as part of their assessment and treatment. In addition, we saw evidence of the same standard consent being obtained from parents for some of the 16 year old young people on the ward.

The ability of children/young people to make decisions for themselves was included in the ward's admission checklist. These had been ticked to confirm that assessments of Gillick competency (for children below the age of 16) and capacity (for young people aged 16 and 17) had been carried out in relation to admission, and to receive treatment. However, we were unable to find copies of these assessments. We asked staff where we would find these assessments but we were given different answers by different staff.

We subsequently asked the trust to provide us with three copies of Gillick competency assessments which they had carried out, and three copies of mental capacity assessments. The trust later wrote to us and clarified that whilst they carried out assessments of capacity and competency, the ward did not formally record these. The trust advised us that the ward was to rectify this with immediate effect.

Training of staff in relation to the Mental Capacity Act was not mandatory. This meant there was a risk that decisions and interventions being made in relation to those who lacked mental capacity may not be carried out in line with the law.

Good

Are services safe?

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

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

Summary of findings

Are child and adolescent mental health 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**

Whilst we saw care records were in place, and were being used by staff, there was also evidence of some gaps in children's/young people's observation records. Some of these gaps were of a significant duration. On balance, however, we concluded these gaps were indicative of a lack of record keeping as opposed to staff not carrying out observations in accordance with care plans.

Following on from the previous CQC inspection, improvements had been made with regards to the environment's safety and management of potential risks. Examples of such improvements included sealing potential ligature points and installing collapsible rails. Despite these improvements, there were a minority of doors whose closing mechanisms could present as a ligature risk. These doors, however, were in areas where staff would be present which meant the risks to children and young people were reduced and able to be managed. We saw risk assessments had been carried out by the trust to identify where potential hazards were located in the unit; whilst many of the potential hazards had been identified and plans put in place to reduce such risks, not all of the door closing mechanisms had been identified by staff as part of their own risk assessment process.

Some staff did not know where the oxygen masks, used as part of resuscitation, were kept. These were eventually found after asking different staff and some time delay. We saw that whilst most medication charts had been fully completed, several charts did not record how much children/young people weighed. Given that the doses of some medications can vary depending on a person's weight, this lack of recording presented a potential risk of a child/young person being given the wrong dose of medication.

We noted that all bedrooms were on the same corridor and a lack of separation between male and female sleeping areas risked the privacy and dignity of children and young people not being protected. Unit staff were aware of this risk but gave inconsistent explanations of how this was managed. At the time of our inspection, how these risks were managed was not formally documented. This meant there was a risk that privacy and dignity issues were not being robustly and consistently implemented. The trust responded to this promptly by ensuring a written risk management process was produced and shared with us within a few days of the inspection having taking place.

We found the unit to be both clean and tidy. Access to the unit was controlled by locked doors which required a security number to be opened. This security number was known only to staff. Controls on who could access the unit meant children and young people were being protected from others who had no right or reason to be on the premises.

The majority of ward staff who we spoke with were of the opinion that staffing levels on the unit were now sufficient. According to the unit manager and assistant manager, staffing levels on the unit had recently been increased. This increase was in response to the demands being put on staff and to ensure children's/young people's needs were being met. This increased staffing also meant the service was adhering to best practice guidance which had been issued by the Royal College of Psychiatrists regarding safe staffing levels. Should additional staffing be needed, for example at times of staff sickness and enhanced levels of observations being needed, then ward managers were able to authorise, by themselves, the deployment of additional staff. It was the view of the young people we spoke with that staffing levels on the unit were good and that staff were always available if they needed support.

Good

Are services safe?

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

Records we reviewed contained completed risk assessments. In order to identify and appropriately respond to any safeguarding concerns, safeguarding processes for both adults and children were in place. During our interviews with staff, they were able to explain what actions they would take if they had concern about a person's safety and welfare. We saw documentation in one of the care records we reviewed which showed how the unit worked in collaboration with social services in relation to a safeguarding concern.

All of the children/young people who we spoke with, on the unit, felt safe.

Our findings

Safe and clean ward environment

Safe and clean ward environment

We found the ward to be both clean and hygienic and saw cleaning staff carrying out their work.

A system was in place to monitor the unit's fridge temperature, and its contents for any food items becoming out of date. However, we found one dairy product which was out of date and several food items had been opened but had no date of opening recorded on them. This meant the monitoring system which the unit had in place was not sufficiently robust and there was a risk of out of date food being consumed.

The ward's clinic room was similarly clean and tidy. Resuscitation equipment and medication was available and there were records of daily checks having been carried out. There was some confusion, however, amongst some of the nursing staff regarding where the oxygen masks were kept. This confusion and delay could have resulted in an increased risk to the welfare of a patient who was in need of emergency resuscitation.

The doors to the ward were locked. Doors could only be opened by using a security number which only staff had; this helped to ensure that only people who were authorised to enter the ward, and have access to the young people, could gain access. It also helped to safeguard children's/young people's safety.

We saw work had been undertaken by the trust to reduce the number of ligature points which could be used by young people to self-harm; for example, collapsible hand rails and collapsible curtain rails had been fitted. However, we saw the wardrobes in young people's rooms were free standing and there was a risk they could be pulled over either accidentally or on purpose.

We saw evidence that an environmental risk assessment had been undertaken and reviewed with actions taken to minimise the risks identified. Risks identified, and actioned, by the trust included parts of the building which could be used to self harm, a loose fan, and exposed wires. We did see, however, several doors within the unit which had door closing mechanisms which could still create ligature points and not all of these mechanisms had been identified on the risk assessment. Staff informed us they would always be present in these areas. This meant the potential risks were reduced and able to be managed.

Safe staffing

At the time of our inspection, staffing levels on the unit were sufficient. The manager of the service explained that the ward operated on three different shifts, and there was an overlap at the change of shifts to help facilitate handover.

This arrangement was confirmed by another manager and the staff rotas. The unit manager told us staffing levels were based on the recommended minimum levels which had been outlined within guidance issued by the Royal College of Psychiatrists.

Systems were in place so that additional staff could be brought in where needed, for example if staff were off sick or if there was an increased number of patient observations to be undertaken. Authority to approve additional staff being brought in could be given by the ward manager. This meant that the ward was able to respond quickly to any staffing pressures which arose.

Staff and managers recognised that there have been times when they had been short staffed and had relied on external staff. In addition they told us that if they used agency or bank staff they would try, wherever possible, to use the same staff so as to minimise any disruption to patient care. Medical cover was provided by a consultant psychiatrist, specialist registrar and senior house officer. Staff we spoke with said any requests for help from the psychiatrists were promptly responded to.

Good

Are services safe?

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

Young people we spoke with were satisfied with the levels of staffing on the unit. One young person said: "At times it appears there are more staff than patients on the ward." A different young person spoke of staff being "always there" to give help should they need it.

Assessing and managing risk to patients and staff

We reviewed a sample of care records and found that risk assessments had been completed. The assessments incorporated issues such as the risks of violence and aggression, exploitation, self-harm and suicide. The ward manager told us that prior to a young person being admitted to the ward there would usually be a pre-admission assessment carried out to determine if admission to the unit was appropriate. Some circumstances arose, however, when a patient who was very well known to the unit may be admitted without having a formal pre-admission assessment, or if an admission was required in an emergency.

We saw that young people admitted to the unit had been risk assessed on admission and these assessments were documented in the young person's record(s).

There were gaps in relation to the observation charts of four young people; some of these gaps were of a significant duration. For instance, in one young person's care record the young person should have been observed every ten minutes by staff. The young person's observation records had an occasion when the records were blank for 3 hours 50 minutes. On another occasion the young person's observation records, whilst subject to ten minute observations, were blank for 1 hour 50 minutes. We saw, from the risk assessments which had been completed with respect to the young people who had gaps in their observation records, that the young people were on observations because various risks had been identified. Examples of these risks included risks of self harm. We discussed these gaps with staff who assured us that observations had taken place but that they had not recorded them.

Staff we spoke with were aware of their safeguarding responsibilities and of the processes which needed to be followed should a safeguarding concern arise. Similarly, staff we spoke with were aware of the trust's safeguarding lead and how they could be contacted for advice and assistance. We saw an example of how the unit worked with the local authority in relation to a safeguarding concern.

The ward had input from a pharmacist. Doses of medications had, in most cases, been adjusted to take in to account young people's low body weight. Access to medication was controlled and secure. Fridge temperatures were monitored to ensure medicines were being stored at the correct temperatures, and although no controlled drugs were in use at the time of our inspection appropriate arrangements were in place to manage these situations should they arise.

There was also evidence, however, which showed medication management processes had not always been followed. For example, in three of the nine medication charts we reviewed the children's/young people's weight had not been documented. This documentation was important because the dosage of some medications is dependent upon the person's weight. We brought this to the attention of staff to be rectified

Reporting incidents and learning from when things go wrong

All staff we spoke with were aware of how to report any incidents of concern. We found the incident reporting system used was paper based. We saw examples where incident forms had been completed and appropriate issues had been identified by staff. We saw evidence that actions had been taken in response to reported incidents. Such actions included increased levels of observations, medication changes and repairs being carried out by maintenance staff.

Staff told us that following any significant incidents, de-briefs would be provided so that staff were adequately informed and supported. The ward manager we spoke with was keen, however, to make local processes more robust to support learning from incidents.

We saw evidence that the trust circulated a 'lessons learnt' email bulletin to staff to help ensure learning from incidents was shared. Significant incidents were also discussed in the unit's team meetings. Some of the staff who had been involved with significant incidents were able to tell us about debriefings which had taken place and how they reflected upon whether they could have done anything differently.

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

Are child and adolescent services effective?

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.

We found care plans had been formulated so that children's/young people's needs were being met. Care plans we reviewed were both up to date and had been reviewed on a regular basis. The care plan reviews had been carried out on a multi-disciplinary basis. We found the physical health needs of young people had not been overlooked and physical health care interventions had taken place. Examples of such interventions included bloods tests being completed, weight monitoring, food intake monitoring and kidney scans.

The unit staff consisted of multi-disciplinary team (MDT) and each child/young person had input from different professionals. Such professionals included occupational therapy, psychology, medical and nursing staff.

Staff were aware of best practice guidance in relation to child and adolescent mental health, such as NICE guidance and guidance issued by the Royal College of Psychiatrists. Audits were undertaken to examine how the unit adhered to these.

Activities were available for children/young people on the unit. We found a programme of activity for each young person was devised which included education, and other group and one-to-one activities. However, we noted that activities were not scheduled for evenings or weekends. We received negative feedback from several of the children/young people who spoke with us about their activity programmes. Some children/young people said they got bored on the unit and some children/young people felt the activities which were made available to them did not always meet their needs.

Whilst the trust required staff to participate in mandatory training, we found mandatory training for many of the unit's staff was not up to date. To illustrate this, figures provided to us by the trust indicated that the majority of ward staff were not up to date with essential life support training and the majority of unit staff were not up to date with their safeguarding level 3 training.

Some Mental Health Act 1983 (MHA) processes were being appropriately followed. For example, children/young people who had been detained under the MHA were given their rights, as is required by section 132 MHA. However, staff did not always promptly follow the procedure regarding the independent scrutiny of MHA paperwork. This meant there was a risk that the statutory paperwork regarding a child's/young person's detention may not be accurate and complete. There was also a risk that any failure to comply with the procedural requirements of the MHA may not be promptly identified. A shortfall was similarly identified with respect to the unit's compliance with the Mental Capacity Act (MCA). For example, the parents of some young people were being asked to give signed consent for various decisions related to the young people's care even though there is a general presumption in law that young people are deemed to have capacity to make decisions for themselves.

Training in relation to the MCA was not mandatory. This meant there was a risk that decisions taken and carried out for those who lacked mental capacity may not be in line with the law and the requirements of the MCA code of practice. Whilst some staff had received training in relation to the MHA, the training of staff in relation to the MHA was also not mandatory. This meant there were risks that care and interventions, for those who came within the MHA's powers, may not be carried out in accordance with the law.

Our findings

Assessment of needs and planning of care

Assessment of needs and planning of care

Care plans were in place to meet both identified needs and risks. Examples of the care plans which had been formulated included plans regarding observations, leave and meal plans. We saw care plans were reviewed and regularly discussed at the ward's multi-disciplinary team meeting. The care plans we sampled were up to date.

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We found attention had been given to children/young peoples' physical health. For example, we saw from the records we sampled that physical health assessments were conducted when children/young people were admitted to the ward. We saw examples of blood tests having been undertaken, children/young peoples' weights being monitored and physical investigations having been completed.

We spoke with the unit manager about how children/young peoples' physical health was managed within the unit. We were told that if a child/young person developed a physical health problem, they would be reviewed by one of the unit's doctors. If it was an issue outside of the doctor's expertise then the child/young person would be reviewed by their own GP, seen in the accident and emergency department or transferred to the paediatric unit at the local general hospital.

A range of tools were being used as a means of monitoring young people's mental health. Examples of such tools included the Health of the Nation Outcome Score for Child and Adolescent Mental Health ('HONOSCA'), strength and difficulties questionnaires ('SDQ'), and the Children's Global Assessment Scale ('CGAS').

Best practice in treatment and care

Staff we spoke with were aware of various best practice guidance such as those issued by the National Institute for Health and Care Excellence (NICE). A range of audits took place to monitor compliance with NICE guidance. Examples of NICE guidance audited included the guidance regarding depression, psychosis and the prescribing of anti-psychotic medication. Medical staff we spoke with had confidence in the systems and processes which were in place to manage children's/young people's physical health problems. Medical staff also spoke to us about a range of physical investigations they would frequently arrange, and spoke of how they ensured they worked closely with other medical professionals regarding the physical health of children/young people.

We found activities were available for children/young people and each young person had their own activity timetable which included education and other activities such as art, creative writing and relaxation. Activities were not, however, scheduled for evenings or weekends. Most young people we spoke with told us they were often bored on the unit. One young person described the activities available as being "not interesting" and went on to say that being bored made their depression worse. A different young person was of the view that the activities "are not facilitating a young person's needs."

We spoke with the unit manager about how activities were arranged and coordinated. We were told that the unit tried to arrange activities which were in response to individual children/young people and that most of the planning tends to fall upon the occupation therapist. There was a recognition that this was a large responsibility for one person; we were further told that the occupational therapist was keen to try and establish a group of staff who would be able to help with the planning and coordination of activities in order to better meet young people's needs.

Skilled staff to deliver care

Managers of the service outlined to us the range of staff working within the unit. This consisted of psychology staff, occupational therapy staff, nurses, health care assistants and cleaning staff. Medical cover was available from a team of psychiatrists. The unit also had teacher input along with input from a dietician. During our inspection, we saw a range of these disciplines working in the unit. Care records we reviewed contained entries which had been made by a range of different professional disciplines.

We did, however, identify shortfalls with regards to adherence to mandatory training. Information provided to us by the trust show that 90% of ward staff did not have up to date training with regards to emergency life support, and 38% of ward staff were not up to date with training regarding intermediate life support. 45% of ward staff were not up to date with safeguarding level 2 training whereas 63% of ward staff were not up to date with their safeguarding level 3 training.

Multi-disciplinary and inter-agency team work

Information provided to us by the trust showed there were three handovers where information regarding young people on the unit was shared between staff leaving a shift and those starting a shift. The unit kept a record of these handovers which contained summaries of the key points which were discussed. The sample of handover summaries we reviewed included appropriate information such as the mental state of young people, young people's education commitments and plans, summaries from the multi-disciplinary team meetings and young people's care programme approach meetings.

Are services effective?

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Staff told us that MDT meetings took place on a weekly basis and that at these meetings all young people, and key aspects related to their care would be discussed and reviewed. We saw evidence from the care records we reviewed that MDTs had been taking place frequently. We attended an MDT meeting and observed the care related to two different young people being discussed. The MDT meeting consisted of three doctors, five nurses, an occupational therapist, clinical psychologist and a teacher. During the MDT discussions, we observed appropriate aspects of young people's care were being discussed. For example, there was a discussion about a young person's education and schooling, along with dialogue about discharge plans, consideration of aftercare and how the unit could engage with a young person's family to help better ensure there was consistency in care.

We found evidence which showed how the service worked with other agencies. For example, in the MDT we observed, we heard about discussions which had taken place with a young person's college, and in the care records we reviewed we saw a range of entries where there had been liaison with, for example, GPs, other medical specialties, schools and social services.

Adherence to the MHA and the MHA Code of Practice

We checked whether those young people, who were detained under the Mental Health Act (MHA) at the time of our inspection, had been advised of their legal rights and found evidence that this had been carried out. A checklist was in place which guided staff on how frequently these rights should be given, and explained, to detained young people.

Staff told us they kept dedicated folders for all paperwork which related to a young person's detention under the MHA. We looked at one of these and found that a copy of the MHA assessment carried out by the approved mental health professional (AMHP) was not within the dedicated MHA folder. We asked staff about this and they could not locate it.

At the time of our inspection, there was no evidence on the ward to indicate whether the statutory MHA paperwork had been independently scrutinised. This scrutiny is a requirement within the MHA and MHA Code of Practice to ensure the grounds for young people's detentions were in accordance with the law.

Evidence of this scrutinisation having taken place was later provided to us by the trust. We were concerned about how long it took for the independent scrutiny to happen in some cases. For example, in one young person's case the detention paperwork was not medically scrutinised until 13 days after the date of the young person's detention. In another young person's case the statutory paperwork was not medically scrutinised until 8 days after their detention. These time delays meant there was a risk that the statutory paperwork regarding a child's/young person's detention may not be accurate and complete. There was also a risk that any failure to comply with the procedural requirements of the MHA may not be promptly identified.

Whilst some staff had received training in relation to the MHA, training was not mandatory. Given that staff were at times required to care for children and young people who were detained under the MHA, this lack of mandatory training meant there was a risk that the care of detained children/young people could be carried out in a way which was not in accordance with the law or the MHA code of practice.

Good practice in applying the MCA

We saw some care records which showed parents had been routinely asked to give written consent for certain decisions even though there is a general presumption in law that young people are deemed to have capacity to make decisions for themselves. As an example, we saw the parents of a 17 year old young person had signed consent for urgent medical and surgical treatments which might be needed, and to give permission for the young person to participate in certain activities as part of their assessment and treatment. We saw evidence of the same standard consent being obtained from parents for some of the 16 year old young people on the ward.

Whilst parents were being asked to give consent for certain decisions, the unit's admission checklist included the issue of Gillick competency (for children below the age of 16), and mental capacity (for young people aged 17). In the records we sampled we saw these sections had been ticked to confirm that assessments of Gillick competency and mental capacity had been carried out in relation to admission, and to receive treatment. We were unable to find records of these assessments, however. We therefore asked the trust to provide us with three copies of competency assessments which they had carried out, and three copies of mental capacity assessments. The trust

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Requires Improvement

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later wrote to us and clarified that whilst they carried out assessments of capacity and competency, the ward did not formally record these. The trust further advised us that the ward was to rectify this with immediate effect.

Training in relation to the Mental Capacity Act (MCA) was not mandatory. Given that the ward cared for young people aged 16-17, and that the decision making provisions of the MCA applies to this age group, a lack of mandatory training meant there was a risk that interventions could be delivered in a way which was not in accordance with the law or the requirements of the MCA code of practice.

Good

Are services caring?

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

Summary of findings

Are child and adolescent services caring?

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

Young people said that most staff were both polite and respectful towards them. Whilst observing care taking place, we saw staff to be both caring and respectful towards the children/young people who were on the ward. We saw children/young people appearing at ease with staff and noted the unit's atmosphere to be calm and settled. Records referring to children/young people were written in a professional and non-judgemental manner, and we saw staff discussing children's/young people's care in the multi-disciplinary team (MDT) meeting in a respectful manner.

Children and young people had an awareness of the care plans which were in place for them and there was evidence of children/young people having been involved in the development of these plans. Parents/carers of children/young people were equally involved and given opportunities to give their views, discuss any concerns and give feedback. In addition to children/young people giving views about their care within the care planning process, ward community meetings were held for children/young people to raise any concerns and express their views.

Children/young people did not routinely attend the MDT meetings where their care was discussed by staff. Children and young people were able to contribute to the MDT discussion, offer their views and express their wishes, however by means of completing a written sheet. This was then read out within the MDT, considered by the MDT and subsequently fed back to the child/young person.

Our findings

Kindness, dignity, respect and support

We saw staff interacted, in both a caring and responsive manner, with children/young people. Children and young people on the ward were seen to be relaxed with staff. The ward's atmosphere was calm and settled. We saw staff gave children and young people choices and staff respected, where appropriate, their wishes.

Care records we reviewed were written in a respectful manner using appropriate and non-judgemental language.

During the multi-disciplinary team (MDT) meeting which we attended, we saw children and young people were discussed, by staff, in a professional manner. Children and young people's individual needs were considered within the MDT discussion.

We received mixed feedback from children/young people regarding the care provided at the Lime Trees unit. One child/young person described staff as being "respectful" and spoke of how staff would take time to listen. A different child/young person said some staff were "polite and respectful" but others had "different attitudes towards some patients". A third child/young person had similar views telling us that staff were "very respectful" apart from "… the odd staff who act indifferent towards patients". A different child/young person spoke to us about how staff were respectful and took time to listen to their concerns.

The involvement of people in the care they receive

We found evidence, in the sample of care records which we reviewed, that young people had been involved with their care planning. Records contained an admission checklist which set out certain tasks which had to be carried out when a young person was admitted. This included showing the young person around the unit and giving them information. Community meetings took place on the ward. These meetings, which were usually chaired and documented by young people themselves, were a forum where young people were able to discuss matters of importance to them and raise them with ward staff. On reviewing the minutes to these meetings, we saw that young people had raised unhappiness about a particular food type which was frequently being offered and that alternatives had been provided in response to the young people's feedback. Similarly, we saw how some young people had expressed a wish for there to be a 'Play Station 3' available for them to play on. We saw that in order to pursue this possibility, a young person had been tasked with finding prices to purchase one and that this would then be considered by managers to determine if one could be purchased.

Good

Are services caring?

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

We noted that whilst community meetings had taken place over recent weeks, there had been gaps prior to this when the meetings had not happened.

All young people we spoke with confirmed they were involved in various aspects of their care. For instance, one young person told us: "I am normally informed about all treatments" and "I read my care plan and after sign that I have read it." Similarly, a different young person told us they were aware of their care plan and "… will sit with the professionals to discuss my treatment." We saw additional evidence in the sample of care records which we reviewed of young people's signatures to confirm they had been part of their care planning.

We attended a multi-disciplinary team (MDT) meeting and observed the discussions which took place regarding two young people. We noted from our observations, however, that young people were not present for these discussions. We spoke with staff about this and were told young people did not usually attend these discussions primarily for two reasons. Firstly, in the past, when young people had been asked if they would like to attend the meeting young people did not want to attend. Secondly, we were told it would be "logistically difficult" for each young person to attend given the limited time which was available. We saw that in order for young people's views and wishes to be considered at the MDT, young people were asked to complete a form which the MDT would read. The young person's requests and views would be considered and the discussion later fed back to the young person. One young person we spoke with was not happy with this because they believed they should be present when their care was being discussed and said they would like to be present for their MDT meetings.

There was evidence in the care records we reviewed of parents/carers being involved in the care of young people. For instance, we saw letters had been routinely sent to parents/carers when a young person was admitted which invited them to attend a parent consultation meeting where the young person's admission to the unit could be discussed. We saw invites to attend Care Programme Approach (CPA) meetings had been sent to parents/carers, and additionally saw numerous entries within care records which showed discussions had taken place between staff and young people's parents.

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

Are child and adolescent services responsive to people's needs?

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

There were some limitations to the building and its environment. For example, we noted that the unit had narrow corridors; we saw people either had to stand back in a door way to let another person pass, or stand aside at an angle as otherwise there was a risk of entering another person's personal space whilst passing on the corridor. A different example was related to window catches having been removed and windows sealed shut as a short term strategy to keep children/young people safe from potential ligature risks. Whilst we received feedback from both staff and children/young regarding a lack of air flow and temperature fluctuations this had caused, the service had taken steps to manage and minimise the impact. For example, fans were made available and a ventilation system had been installed.

The service had a range of rooms and equipment to support the care and treatment of children/young people. For example, there was a private clinic room, a lounge area and conservatory. The unit had a large outside area although in order to maintain children's/young people's safety and ensure monitoring could continue access to this was controlled and supervised by staff. Educational facilities were also on site.

Provision was in place which ensured children and young people were able to maintain contact with family and friends. This included having a stock of mobile telephone phones, which did not have a camera facility so the privacy of others was maintained, and having a cordless telephone which children/young people could take to a private room in order to make phone calls.

Information on a range of issues was made available to children and young people. For example, we saw that when children/young people were admitted to the unit they were given information regarding their rights and how to complain. There was information on one of the corridors regarding how children/young people could access advocacy services and the CQC.

It is important to acknowledge that the service recognised there were challenges of providing optimum inpatient care because of the building's physical constraints. In response to this, the service had reduced the number of children/young children they admitted, to a maximum of nine, to ensure the needs of children/young people on the ward were able to be met. The service was also working closely with commissioners, and other stakeholders, regarding the plan which was already in place for the unit to be relocated elsewhere in December 2014.

Our findings

Access, discharge and bed management

At the time of inspection, the Lime Trees unit was operating on a reduced number of beds. This was primarily because of constraints and limitations of the building and the need to ensure that both children and young people were kept safe. A plan was in place for the unit to be re-located, by the end of 2014 to a new building, in order to provide a more appropriate environment and to enable care to be given for an increased number of young people. The unit was therefore in the process of entering a transitional phase. Managers of the service were working closely with commissioners regarding service provision and bed management at a time of change.

We were informed by one of the managers that there usually was not a waiting list but at the time of inspection there was a small waiting list of young people and children who required a pre-admission assessment. This list had arisen as a result of the unit's consultant psychiatrist being on sick leave. Whilst a consultant psychiatrist from another team was providing cover for the ward, the trust was in the process of trying to recruit dedicated consultant cover for the inpatient ward.

The ward environment optimises recovery, comfort and dignity

The Lime Trees unit contained a number of different rooms and facilities. For example, there was a lounge area for children and young people, a visitor's room, clinic room, bedrooms, toilets and bathrooms. In a separate building, located on the same site, was an education facility where children and young people could attend for school.

Requires Improvement

Are services responsive to people's needs?

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

In the lounge area, there was a television and other games for children and young people to use.

There was an easily accessible kitchen and attached conservatory area which led to a large outside space. Access to this outside space was controlled by staff because of health and safety reasons. Such reasons included a number ligature points which could be used by children and young people to self harm and access to an old derelict court area which had damaged fencing.

Young people were allowed to personalise their bedrooms. Bedrooms were not en-suite. Young people used communal bathrooms and toilets. Males and females were encouraged to use separate bathrooms and toilets within the sleeping area which were at opposite ends of the corridor. This encouragement was given to reduce the need for children/young people to pass the bedrooms of children/young people of the opposite sex. Both staff and managers we spoke with were aware of the potential risks, upon the privacy and dignity of children/young people of the opposite sex, associated with having different genders within the same sleeping area. Staff told us these risks were managed by always ensuring there was a staff member present on the corridor when children/young people were in that part of the building. We noted, however, that different staff we spoke with told us differently about how these risks were managed. For example, one staff member told us one member of staff always sat in the corridor at night. A different staff member told us staff would sit in a room at the end of the corridor (which was behind the bedroom corridor's door where visibility and sound could be impaired to any movement on the corridor). Another staff member said two members of staff stayed on the corridor. We found that at the time of the inspection there was no formal local policy or process to ensure staff were consistent with their approaches to robustly manage the potential risks. When we raised this with managers, the trust responded to this promptly and ensured a written local risk management policy was put in place. A copy of this was provided to the CQC within a few days of our visit.

Doors to bedrooms contained in-built viewing panels which could be opened and closed from the inside by young people, and outside by staff. One did not work. One of the three showers did not work. Staff told us they would report this and ensure it was repaired.

The unit had narrow corridors; we observed people either had to stand back in a door way to let another person pass, or stand aside at an angle as otherwise there was a risk of entering another person's personal space whilst passing on the corridors. We also saw staff struggling to find available space to meet with young people privately and noted space for families to meet with children/young people was equally limited.

To keep children and young people safe from potential ligature points, window handles had been removed from young people's bedrooms and their windows had been sealed shut. Both staff and young people we spoke with made comments about the unit's temperature. One staff member, for example, told us there was "no happy medium" and that it was "either too hot or too cold". One young person told us: "The place is too hot in summer and sometimes too cold."

Prior to our inspection the trust had recognised the difficulties which the building presented and had already put in place measures to minimise the impact on both staff and children/young people. For example, fans were made available and a ventilation system was in place. The trust further recognised that these interventions were only to be a short term measure until the unit was moved in December 2014. The CQC recognises that the trust has worked proactively with commissioners to facilitate the relocation of their service to a new building and that some of the challenges posed by the environment were outside of the trust's control.

Ward policies and procedures minimise restrictions

Some young people we spoke with told us that they were not allowed to go to their bedrooms during the day because staff locked them out. We spoke with staff about this and they denied this happened. We did see however in some incident reports which had been completed that responses to some incidents involved ensuring young people remained in the unit's lounge.

We found appropriate arrangements were in place regarding the use of mobile phones. These arrangements were in the form of young people not being allowed to have a mobile phone which had a camera. We were told this restriction was in place to prevent photos potentially being taken of other young people without their permission and knowledge, or whilst being unwell, and the risk of such photos being circulated on social media sites. Instead of adopting a blanket ban on mobile phones, we found the unit was able to provide mobile phones, without

Requires Improvement

Are services responsive to people's needs?

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

a camera facility, so that young people could use their SIM cards in that phone instead. The ward did have an appropriate expectation, however, that mobile phones were not to be used during week days or meal times in order to prevent disruption from schooling, activities and eating.

Some young people were unhappy that there was no internet access within the unit. We spoke with the manager about this and it was confirmed that the only internet access was available in the separate education unit.

Meeting the needs of all people who use the service

There was recognition that given the limitations of the ward environment, the unit in its present form may not be in a position to meet the needs of all young people, particularly if the young person has a physical disability. The trust is aware of this and plans are in place for the unit to be relocated to a new, more appropriate building.

We found that access to the service was determined purely on clinical need. The service was aware of its responsibilities to ensure equity of access to all young people regarding of, for instance, their gender, race, sexuality, religion or language.

Interpreting services, for children, young people and families/carers whose first language was not English, were available for staff to access if these were required.

Listening to and learning from concerns and complaints

We saw evidence on the unit that young people were being informed of their rights to raise concerns and give feedback about their care. For example, we saw notices which advised people on how to make a complaint, and we saw there were comment boxes for young people to write down their views and opinions and submit them to staff. We saw information was available to young people about how they could contact the Care Quality Commission and their local advocacy service. The majority of young people we spoke with were aware of how they could make a complaint should they wish to do so. All care records which we reviewed documented when young people had been advised of their rights and given information about how to raise concerns.

Are services well-led?

Good

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

Summary of findings

Are child and adolescent mental health services well-led?

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.

Only half of the staff we spoke with were able to identify the objectives and values of the organisation. We did, however, observe staff to deliver care in a way which was consistent with the organisation's values.

Whilst supervision and annual appraisals took place, they did not occur consistently. At the time of our inspection, however, a plan to ensure supervision took place was being devised by one of the managers.

In order to make sure that the service delivered a safe and good standard of care, a range of audits and checks were carried out. We found, however, that the quality monitoring which was carried out was not always sufiiciently robust. For example, gaps within observation records had not been identified, or addressed, by managers despite gaps having been previously raised with the service during the CQC inspection in December 2013.

There was an absence of administrative support for the unit.

Staff we spoke with were aware of their responsibilities, what was expected of them and who they were accountable to.

Most staff who we interviewed as part of our inspection felt supported by their colleagues, their management and the trust. However, some staff we spoke with, which consisted of different professional disciplines and different grades, reported feeling stressed from the number of changes they perceived were being introduced within the organisation and the move towards electronic patient records.

The service had participated in a peer-review, as part of the Quality Network for Inpatient CAMHS, so that areas for development could be identified and the quality of service be improved.

Our findings

Vision and values

The trust had an organisation vision and strategic objectives in place. Half of the staff we spoke with were able to identify some of these objectives and values. We saw evidence, however, of staff delivering care in a way which was in accordance with the trust's vision and goals. For instance, we observed staff delivering care in a compassionate way, there was partnership working with young people and other organisations, and there was evidence of care being delivered in line with best practice guidance.

Good governance

We found that a line management structure was in place and that staff had an understanding of the different tiers of seniority within the trust.

We spoke at some length with the unit manager about the supervision and appraisals of staff. We were told that it was compulsory for all staff to receive supervision and annual appraisals. We found that a supervision structure was in place which identified who was responsible for supervising particular staff. The manager shared with us the outcome of a recent audit which they had undertaken which looked at how compliant the unit was with their supervision targets. The audit results shared with us showed that for the months of April 2014, May 2014 and June 2014 an average of 61% of supervisions had been completed. The manager spoke to us about some of the limitations in the data in that they did not take in to account, for instance, sickness. The manager of the service went on to outline what steps they would be taking to improve this; this included raising the issue at a forthcoming team meeting and speaking with staff members, where necessary on a one-to-one basis to remind them of what was expected from them.

Are services well-led?

Good

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

Staff we spoke with were aware of the importance of supervision although we did receive mixed feedback from staff regarding how frequently supervision actually took place. This feedback, however, was consistent with the audit which had been carried out which identified that supervision did not always take place as often as required.

Appropriate delegated responsibility had been given to the ward manager in relation to authorising additional staff, such as bank staff or agency staff, when this was required. This meant the management of the unit was able to respond promptly in order to ensure the needs of children/young people were met. Managers of the service had recognised the demands being placed upon staff and the needs of children/young people and had responded appropriately by amending the staffing rotas so that there was a minimum of two qualified nurses on shift both night and day.

We found evidence which indicated the presence of other governance processes at a local level. For example, we saw examples of where incidents had been appropriately identified, reported and acted on. We saw audits had taken place regarding, for instance, the ward's environment where potential ligature points were identified and steps taken to reduce the identified risks. Examples of other audits which were undertaken as part of the unit's governance included audits of care plans, compliance with NICE guidance and mattress checks. There was also evidence, however, that some of the checks which were carried out were not sufficiently robust. For example, the gaps in some of the records had not been identified and rectified promptly, and the routine monitoring of the unit's fridge had not identified opened products with no dates of opening having been marked on the products. The lack of such robust checks meant there was a risk of unsafe care being delivered.

We found that the unit did not have any dedicated administrative support. It was the view of some staff that this lack meant time was being taken away from young people and their care.

Leadership, morale and staff engagement

Some staff described their working environment as being "generally supportive" whilst others spoke of there being "very high stress levels" and "too many changes." Some staff expressed feeling anxious about the forthcoming planned relocation of the unit to another site, and some staff had similar anxieties about the shift towards a computer based care records system.

Staff reported feeling supported with regards to safeguarding matters in particular, stating the trust's safeguarding lead was both approachable and easily accessible. Positive comments were received about the support provided by the medical staff and their responsiveness when it was needed.

None of the staff we spoke with had any negative feedback regarding managers of the unit. Some healthcare assistants, however, wished their roles could be better recognised and have more involvement at the weekly multi-disciplinary team meetings.

Staff gave us consistent positive feedback regarding de-briefs which occurred after any significant incidents. Similarly, staff reported feeling well-supported by both colleagues and managers after any significant incidents had happened.

Commitment to quality improvement and innovation

Staff we spoke with presented themselves as being committed to good quality care and being open to areas where they can improve. During the inspection, some situations arose where staff recognised improvements could be made and they appeared both keen and willing to implement these. There was a commitment to best practice guidelines and the implementation of new ways to work.

The unit had participated in the Quality Network for Inpatient CAMHS which was a peer-review process aimed at improving service quality. This participation showed a commitment by the service to identify areas for improvement and look at how the service provided to children/young people could be developed.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records **Records** The Registered Person had not ensured that service users were protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of an accurate record in respect of each service user which shall include appropriate information and documents in relation to their care and treatment (Reg 20(1)(a)). This was because: At the Lime Trees unit, gaps were found in the observation records of children/young people. The Lime Trees unit did not maintain a record of the mental capacity assessments, or Gillick competency assessments, which they carry out

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **Supporting workers** The registered person did not have suitable arrangements in place which ensured persons employed for the purposes of carrying on the regulated activity were appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard by receiving appropriate training and professional development (Reg 23(1)(a)). This was because:

Compliance actions

- 90% of Lime Trees ward staff were not up to date with regards to emergency life support training

- 63% of Lime Trees ward staff were not up to date with their safeguarding level 3 training

- 45% of Lime Trees ward staff were not up to date with the safeguarding level 2 training

- 38% of Lime Trees ward staff were not up to date with their intermediate life support training