An evaluation for the Therapeutic Learning Centre: A child inpatient and day-patient psychiatric unit in Cape Town, South Africa

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Compulsory Declaration:

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work, or works of other people has been attributed, cited and referenced.

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List of Acronyms and Abbreviations

ADHD	Attention Deficit Hyperactivity Disorder
CAMHS	Child and Adolescent Mental Health Services
CAPS	Curriculum Assessment Policy Statements
CBT	Cognitive Behaviour Therapy
CCTV	Closed Circuit Television
CGAS	Children's Global Assessment Scale
CLP	Consultation Liaison Psychiatry
CPA	Care Programme Approach
CQC	Care Quality Commission
DBS	Disclosure and Barring Service
DBT	Dialectical Behavioural Therapy
DCAP	Division of Child and Adolescent Psychiatry
DOH	National Department of Health
ECG	Electrocardiography
EEG	Electroencephalogram
EMDR	Eye Movement Desensitization and Reprocessing
HONOSCA	Health of the Nation Outcome Scales for Children and Adolescents
HPCSA	Health Professions Council of South Africa
ICAS	Independent Counselling and Advisory Services
IMHA	Independent Mental Health Advocate
IPT	Interpersonal Psychotherapy

M	Monitor Quality Criteria
MBT	Mechanical Biological Treatment
MDT	Multidisciplinary Team
MHA	Mental Health Act
NCS	National Core Standards
NHI	National Health Insurance
NICE	National Institute for Health and Care Excellence
OPU	Outpatient Psychiatric Unit
OT	Occupational Therapy
POCHA	Protection of Children Act
PRN	Pro re nata
PTSD	Post-traumatic stress disorder
QNIC	Quality Network for Inpatient Child and Adolescent Mental Health Service
RCWMCH	Red Cross War Memorial Children's Hospital
SCIMHU	Statewide Child Inpatient Mental Health Unit
SDQ	Strengths and Difficulties Questionnaire
SNAP	Swanson, Nolan and Pelham Teacher and Parent
SOP	Standard Operating Procedure
SPMS	Staff Performance Management System
TLC	Therapeutic Learning Centre
UCT	University of Cape Town
WCED	Western Cape Education Department

WTE	Whole Time Equivalent
YW	You’re Welcome

Abstract

There are value and importance for inpatient and day-patient psychiatric units, particularly for children and adolescents. These facilities, which are scarcely established in South Africa, offer multidisciplinary and multifaceted treatment to persons experiencing varying symptoms and conditions of mental illness. This dissertation presents the findings of an implementation evaluation conducted for the Therapeutic Learning Centre (TLC), a child inpatient psychiatric unit in Rondebosch, Cape Town. The evaluation aimed to compare the TLC's service and programme implementation with international standards. The Quality Network for Inpatient Child and Adolescent Mental Health Service (QNIC) checklist was used to assess the TLC on seven focused categories of service and implementation quality. Data were provided from selected TLC team members, which included mental health practitioners from various fields (e.g., psychology, psychiatry and social work to name a few). Overall, the programme established within the TLC was found to be implemented with fair fidelity when compared to the international unit standards. Most unit standards required and expected to be carried out by an inpatient unit were found to be satisfied by the TLC. There are, however, key aspects of the unit's environment and facilities, staffing and training, care and treatment, and clinical governance that were highlighted as needing improvement. While the research yielded mostly positive results, the evaluator was able to make several recommendations to the TLC stakeholders. This evaluation contributes to limited research and implementation evaluations within the context of child inpatient psychiatric units. Furthermore, the findings are intended to support the promotion of quality psychiatric and behavioural treatment and mental health service policy in these units within South Africa.

Chapter 1: Introduction

The following chapter provides the reader with an introduction to the inpatient and day-patient programme established at the Therapeutic Learning Centre (TLC). The TLC is the evaluand of this research. The unit provides treatment and therapy to children with notable mental, emotional and behavioural difficulties. A literature review of the design, activities and outcomes of such programmes is included in this Chapter along with descriptions of evaluations that have been undertaken at similar facilities. Finally, the reader will be informed of the scope of the implementation evaluation that was conducted and the evaluation questions that guided the research.

The presence of severe mental health problems in children and adolescents is prevalent, both nationally and globally. In 2011, 41.4% of learners between the ages of 14 and 16 in schools across the Western Cape were at medium risk for experiencing mental health problems, whilst 14.9% were found to be at high risk (Morojele et al., 2013). More recently, 20% of children and adolescents have been estimated to possess a mental health disorder (Paruk & Karim, 2016). Cheng et al. (2014) argue that children and adolescents' exposure to vulnerable environments that comprise of poor social support and socioeconomic conditions and disintegrated familial relations tend to exacerbate mental health problems experienced. As a result, mental health service providers experience significant pressure and strain in their attempts to satisfy high demands for treatment. One such line of mental health service is inpatient psychiatric treatment units. Despite experiencing numerous pressures, particularly from staff-skill shortages within the South Africa context (Baynes, 2009), these units are still considered an extremely important component of mental health service for children and adolescents (Ise, Schröder, Breuer, & Döpfner, 2015). This dissertation presents an evaluation of the Therapeutic Learning Centre (TLC), which aims to provide quality inpatient psychiatric treatment and support to children within the Western Cape who are battling with severe mental health difficulties.

Introduction to the Therapeutic Learning Centre

The Division of Child and Adolescent Psychiatry (DCAP) is a mental health facility that provides consultation, clinical services, training, education and research as its core operations. It has one demarcated satellite campus that is situated at the Red Cross War Memorial Children's

Hospital (RCWMCH) in Cape Town, South Africa. Within the DCAP are three distinguishable units: Consultation Liaison Psychiatry (CLP), the Outpatient Psychiatric Unit (OPU) and the Therapeutic Learning Centre (TLC). CLP offers mental health services primarily to hospitalised physically ill children who possess comorbid psychiatric disorders. The OPU provides tertiary outpatient psychiatric services to children aged between 0 – 18 years who are currently school going. Lastly, the TLC, which is the evaluand of this research dissertation, is an inpatient and day-patient psychiatric unit that currently assesses and provides tertiary/quaternary psychiatric treatment for a maximum of 10 children between the ages of 6 - 12 years. On average, between 3 and 5 children attend the day programme established at the TLC. Generally, children who are admitted into the TLC unit are those individuals who have not benefitted successfully from outpatient interventions. Outpatient interventions may comprise of one-on-one consultations that include cognitive behaviour therapy, behaviour therapy and interpersonal psychotherapy – to name a few – provided by a registered mental health practitioner (e.g., clinical psychologist). The overall goal of the TLC is to be a leading contributor to child mental health, by aiming to provide a comprehensive service that modifies maladaptive behaviour, builds competence and fosters belonging in a non-discriminative therapeutic milieu with unconditional respect for the children and their families.

The background of and adjustments to the TLC

The TLC was first established in December 1975 (Dhansay, 2012). Prior to its establishment, maladjusted children had to be admitted to inappropriate and arguably detrimental environments such as medical wards and institutions for mentally handicapped individuals when being treated. The introduction of the TLC enabled children to be assessed and treated short-term in one of the two functioning units: the Day Care Centre at the Child and Family Unit, and the Inpatient Unit of the RCWMCH. Together these units made up the psychiatric day hospital. In 1992, the two units integrated in order to provide one complete therapeutic environment that currently represents the only child psychiatric inpatient unit within the Western Cape (the TLC) (Dhansay, 2012).

Currently, the unit is led by the head child and adolescent psychiatrist who is supported with government funding from the Western Cape Education Department (WCED) and additional sponsorship from the Harry Crossley Foundation. Within the unit a multidisciplinary team exists,

which comprises a child and adolescent psychiatrist, clinical psychologist, social worker, occupational therapist, psychiatric nursing team, registered special needs primary school teacher and a class assistant. The replacement of these nurses proves to be difficult given the gap in experience within inpatient psychiatric units in South Africa.

Admission into the TLC

The direct beneficiaries of the TLC inpatient and day-patient unit are recruited on a referral basis from sources of both public and private sectors. Sources from the public sector include the DCAP outpatient department and the Child and Family Units at the Tygerberg and Lentegeur Hospital. Sources from the private sector include referrals from private child and adolescent psychiatrists and/or clinicians. Referrals who are deemed suitable for admission into the TLC are children with a) school refusal; b) severe suicidality associated with a psychiatric disorder (e.g., major depression); c) psychosis; d) mania; e) severe eating disorders; f) severe disruptive behaviour and emotional/aggressive dysregulation that is not primarily elicited from a conduct disorder; g) parent/care relationship problems; h) severe anxiety/mood disorders (e.g., post-traumatic stress disorder [PTSD]); and/or i) neurodevelopmental disorders (e.g., attention deficit hyperactivity disorder [ADHD]). Referrals who possess primary symptoms of intellectual disability (i.e., moderate, severe or profound) or conduct disorder and/or experiencing school-related difficulties (e.g., bullying) or any physical illnesses with possible organic causes are excluded from admission as they cannot be managed within a psychiatric inpatient setting and alternative treatment recommendations are made to the family and relevant referrer.

After submission of a completed DCAP referral form and relevant reports, the referred child is assessed by the aforementioned multidisciplinary team, which will include a senior registrar as a contributor to the assessment. The assessment process itself comprises of a two-stage preadmission observation of the child and his/her parents/guardians/carers within the confines of a structured viewing room. The assessment process determines the child's suitability for admission into the TLC according to the above-mentioned criteria and additional factors, such as the child's parent's motivation for the intended admission. On the seldom occasion of an urgent admission, the consultant child and adolescent psychiatrist on-call would review the patient, together with the senior registrar on call for the DCAP. Before admission, a medical examination of the child is conducted to exclude an organic cause for the presentation.

In general, confirmed admissions into the TLC may be purposed solely for assessment (three to five weeks), for treatment (six to twelve months) or a combination of the two within a structured normal school week routine. However, the duration from admission to eventual discharge varies substantially between admitted children given its dependence on the nature and severity of their individual conditions and their receptivity to treatment.

Patient treatment modalities and programme implementers

Admitted patients reside at the psychiatric inpatient and day-patient unit from Monday to Friday and return home to their families on weekends. When admitted, the children are provided with an all-inclusive programme that aids them holistically in order to a) promote the development of adaptive skills and behaviour; b) strengthen motivation to learn and improve academic performance; c) improve interpersonal relationships, particularly with family members; and d) provide symptom relief and reduce anxiety. The aforementioned multidisciplinary team, who assesses referred children for their suitability, are the implementers of these varied activities. Refer to Table 1 for an overview of each team member's core responsibilities in the unit.

Each patient possesses a treatment framework that is based on their individual cases and needs. These treatment frameworks will include suggestions and input from each member of the multidisciplinary team. This process is a significant contributor to the attainment of the patient's individualised goals that embody healthy and adaptive behavioural modification.

Table 1

Core Responsibilities of TLC Multidisciplinary Team Members

Professional	Core Responsibility
Senior Registrar	Case management. Clarify psychiatric diagnosis. Liaise with medical aid case manager at RCWMH fees office. Medical management: this involves physical examination on admission; arranging appropriate medical investigations; and assist head child and adolescent psychiatrist with medication choices.
Child and Adolescent Psychiatrist	Offer clinical leadership to the team. Provide psychiatric assessment, diagnosis and treatment of mental disorders. Prescribe psychotropic medication when indicated. Monitor treatment outcomes.
Clinical Psychologist	Assessment of the patient to determine appropriate therapy and treatment goals. Conduct individual work with the patient once or twice weekly according to his/her treatment framework. Provide support for families through parent-child attachment work and bridging back to school. Regular review of patient's progress.
Occupational Therapist	Assist the team with a patient's clinical diagnosis. Formulate treatment goals for the patient to master their engagement with play, leisure and schoolwork activities. Provide and facilitate individual and group therapy (Project and Social Skills Group). Provide home programmes for the parents/guardians/carers to implement.
Social Worker	Provide general psychiatric social work services (e.g., psycho-education). Case management. Provide extensive parent/family therapeutic work and home visitations.
Psychiatric Nurses	Assist with the patient's admission to the ward and orientation into the unit. Collect information about the patient (medical and contact details). Conduct special time with the patient. Observe patient's interaction and significant behaviour (e.g., aggressive outbursts). Monitor patient's sleep pattern and appetite. Reinforce behaviour modification programme throughout admission. Supervisor homework completion. Administer daily medication.
Special Needs Primary School Teacher	Observation and assessment of newly referred patients. Coordinate schooling and provision of education on subjects according to the Curriculum Assessment Policy Statements (CAPS) curriculum. Feedback to patient's parents/guardians/carers regarding academic performance and conduct within the class.
Class Assistant	Assist the primary school teacher with classroom procedures and activities.

Programme Activities

Table 2 provides an outline of the daily structure of activities embedded in the TLC unit for the children who are admitted.

Table 2
Typical Weekly Outline of the TLC Inpatient and Day-patient Programme

Time	Monday	Tuesday	Wednesday	Thursday	Friday
07h20-08h00	Children are woken up. Nurses supervise washing, brushing of teeth and breakfast consumption.				
08h10-08h30		News Ring	News Ring	News Ring	News Ring
08h30-09h00	News Ring	Process Art Group Therapy	Mathematics	Mathematics	Afrikaans
09h00-09h30	Mathematics	Process Art Group Therapy	Occupational Therapy	Mathematics	Mathematics (Assessments)
09h30-10h00	Life Skills	Process Art Group Therapy	Occupational Therapy	Social Science	Mathematics (Assessments)
10h00-10h30	Break → Snack	Break → Snack	Break → Snack	Break → Snack	Break → Snack
10h30-11h00	English	Mathematics	Afrikaans	Life Skills	Social Science
11h00-11h30	Occupational Therapy	Afrikaans	English	Life Skills	Swimming/Music Therapy
11h30-12h00	Occupational Therapy	Occupational Therapy	Afrikaans	English	Yoga
12h00-12h30	Stars → Break	Stars → Break	Mindfulness Group	Yoga	Stars → Break
12h30-13h00	Break	Break	Stars → Break	Stars → Break	Break → Return home
13h00-13h30			Lunch		
13h30-14h50			Resting Time		
14h50-15h00			Snack		
15h00-16h00			Homework		
16h00-17h00	Playtime	Playtime	Visiting Time	Playtime	
17h00-18h00	Bath/Shower → Supper	Bath/Shower → Supper	Visiting Time	Bath/Shower → Supper	
18h00-19h00			Free Play		
19h00-19h30	Board Games	Dressing up	Movie Night	Stories	
19h30-19h45			Snack		
19h45-20h00			Brush teeth and toilet		
20h30			Lights out		

As illustrated in Table 2, the programme activities implemented for the patients are structured around a daily schooling programme. Schooling for the patients is coordinated by the registered special needs primary school teacher and one class assistant with supervision by two psychiatric nurses during classroom procedures. The academic section of the schooling programme, provided from 08h00 till 13h00 on school days, is structured for children between grades R/one to seven who are taught subjects according to the Curriculum Assessment Policy Statements (CAPS) curriculum, which includes English Home Language; First Additional Language (i.e., Afrikaans); Mathematics; Social Science; and Life Skills.

As can be seen in the outline, there are many extramural activities that are included in the daily schooling programme. Firstly, before proceeding with the teaching of the essential subjects, the children engage in a daily newsgroup within the class which is facilitated by one psychiatric nurse. This procedure involves each individual child retelling their highlights of the previous day subsequent to finishing school and direct questions toward each other about their respective highlights. As such, a space is created in which a) the child can re-engage and reacquaint him/herself with the others; b) specific behaviours and mood can be observed in a contained setting; and c) gentle transition into academic performance can be elicited. Secondly, every Tuesday the patients will participate in a process art group therapy session, which focuses on self-expression through art in order to develop a patient's self-awareness. This session is facilitated by an external art therapist. Within the session, the patients are taught to use art as a medium through which to communicate a range of emotions, feelings and experiences that allow them to connect with other patients.

Thirdly, occupational therapy sessions occur every Monday and Wednesday, which focus on individual and group therapeutic activities, such as social skills (Wednesdays for 45 minutes) and project group skills (Mondays for 60 minutes) for development. The former focuses on teaching children appropriate ways to interact with other children and adults within a safe environment and teaching them new strategies for coping with social problems. The latter is a task-oriented group that may use tangible products and materials or intangible aspects such as exercises in order to encourage engagement to strengthen functioning in specific performance areas or compensate for existing physical and emotional limitations. Fourthly, brief mindfulness group sessions are implemented and facilitated by the clinical psychologist every Wednesday

after school. The group's focus is on helping the present patients identify feelings and thoughts while providing them with strategies and tools to manage and regulate those. An emphasis is placed on reinforcing relaxation strategies that help the patients independently manage their anger, anxiety and sadness (where appropriate).

Fifthly, every Thursday, patients participate in a yoga session which focuses on various breathing techniques and postures that assist with daily stresses and certain ailments and strengthen a patient's overall concentration in the long-run. Finally, every Friday patients participate in a swimming/aquatic therapy session (first and fourth term) or a musical therapy session (second and third term) depending on the season. The former focuses on strengthening swimming techniques, various motor skills and tactile input for sensory processing within a pool. The latter focuses on the evidence-based use of music interventions to assist the children in coping with fears, anxieties and anger that are aligned with individually established goals. The yoga, swimming/aquatic therapy and musical therapy activities have all been recent inclusions to the overall schooling programme. Both the yoga and swimming/aquatic therapy activities have only been incorporated over the past two years, whilst the musical therapy activity was recently implemented.

Subsequent to school, treatment is centred on rigidly structured routines of homework completion, play-time, exercise and daily living activities such as eating and maintaining hygiene. Furthermore, as you will see in the outline, important treatment modalities are not displayed because the nature of the modalities is specific to the patient's cases and needs and the implementation of some modalities by the relevant team members occur sporadically. Special time is one such modality. This procedure is crucial as it involves 30-45 minutes of one scheduled session a week in which the special nurse applies qualitatively specific activities that benefit the child in a way that is particular to them. These may include encouraging the child to openly share traumatic experiences and express themselves emotionally and engaging with crucial coping mechanisms for the patient's to assist them in managing dysfunctional behaviour. In the instance of uncontrollable problem behaviour that is elicited by a patient, nursing is largely responsible for restrictive procedures as a means to assist in the management of relevantly dysfunctional behaviour. These procedures may comprise of verbal limit setting, a managing chair, the removal of privileges and 'time out'.

Bridging and discharge

Given that a child's admission duration varies between others, periods of reintegrating him/her into the school and home environment and eventual discharge from the TLC inpatient and day-patient psychiatric unit will vary as well. Throughout the patient's admission duration, he/she may exhibit positive receptivity in response to the different treatment modalities provided as observed by the multidisciplinary team members. Positive receptivity may be particularly encapsulated within the ward and classroom context where the majority of the patient's time is spent. Once exhibited and progressively maintained by the patient over time, an individualised plan may be drawn up that outlines a bridging process for the patient. This process involves locating and deciding on an appropriate school for the child to attend which proves to be a significant and costly challenge. In many cases, it is the same school they were registered to before being referred to the TLC. If a new school is identified, an application will be sent to determine whether the child will be accepted or not. After successive meetings with the respective parents, school, child and teacher, the patient is gradually supported in the reintegration back into school and the home/community environment. This is initialised by the patient spending shorter days in the classroom, generally over a two week period.

Subsequent to the successful bridging of the child, a discharge meeting is undertaken with all the relevant parties, including the clinician/senior registrar who is responsible for the case management of the specific patient. A discharge summary is drawn up accordingly which is understood as a document that communicates a patient's care plan to any post-discharge care team. Specific components that may be included in the summary are the reason for hospitalisation; procedures and treatment provided and the patient's discharge conditions. Through the TLC follow-up clinic, post-discharge psychiatric follow-up treatment is provided to some, but not all, children who were admitted into the TLC inpatient and day-patient psychiatric unit. Follow-up treatment generally spans from about three to six months and is usually, based on the availability of service provision.

Programme Theory

Figure 1 below portrays the stakeholder's perspective of the TLC programme theory.

Figure 1. TLC programme theory diagram.

Initial assumptions about the TLC unit are that eligible children who are admitted into the therapeutic milieu environment of the TLC enter having come from a dysfunctional family and developmental circumstances which exacerbate their struggle in coping with notable mental health and behavioural issues. The diverse support that the child receives from the multidisciplinary team at the TLC throughout his/her admission enables him/her to develop key inter-and-intrapersonal skills; manage and relieve high levels of anxiety and stress; learn crucially adaptive social and life skills; and adaptively modify dysfunctional behaviours based on his/her individualised treatment plan. With the notably observed improvement in the child's coping of his/her specific mental health difficulties and well-being and with the involvement of his/her family over time, leading to his/her discharge from the TLC, the child's reintegration into school and the home environment is adaptive and healthy. Furthermore, with and without post-discharge follow-up treatment provided for the child, he/she is enabled to sustain managing and coping with his/her specific conditions and mental difficulties as they proceed with their development.

In concluding the description of the TLC's inpatient and day-patient programme, it is evident to see the multidisciplinary treatment and care that a child receives throughout the duration of their admission in the unit. In order to get more of an understanding of the activities of the TLC unit, the next section will first look to apply research on therapeutic milieu environments to the TLC itself. Subsequent to this section, the evaluator investigated whether the causal assumptions between the TLC's activities and outcomes are plausible by applying findings of outcome and impact evaluations and research to the programme.

Applying the activities and structure of a Therapeutic Milieu Environment to the TLC Unit

What distinguishes inpatient psychiatric care from alternative forms of mental health service is the fact that admission into an inpatient psychiatric unit is usually reserved for children and/or adolescents with severe psychiatric symptomatology (Blanz & Schmidt, 2000; Ise et al., 2015). These are usually patients who have been unsuccessfully receptive towards outpatient forms of treatment. According to Setoya et al. (2011), not only does inpatient treatment, in general, carry a risk of being not only disruptive to the structure of a child's day-to-day living, but it proves to be expensive.

A crucial distinction of inpatient psychiatric units and their approach to the treatment of mental health problems is the establishment of a therapeutic milieu environment that houses multi-model treatment services (Tas, Guvenir, & Cevrim, 2010). This environment is structured with the purpose of controlling, stabilising and improving problematic emotions and dysfunctional behaviour that endorses the application of a goal-oriented treatment plan for an inpatient (Thompson, Shattell, & Martin, 2002). The milieu environment itself is a culmination of safe and secure physical surroundings and the various multidisciplinary team members that employ a range of psychodynamic, pharmacotherapy, family-oriented, cognitive-behavioural and educational therapies (Tas et al., 2010). With a focus of deinstitutionalisation and developing strong social relationships, implemented modalities of treatment aim to enable the patient to utilise problem-solving skills in order cope with personal and environmental stressors (Thibeault, Trudeau, d'Entremont, & Brown, 2010). The multifaceted nature of the therapeutic milieu has been found to be effective in reducing externalising symptoms and school absenteeism and improving family functionality (Boege, Corpus, Schepker, Kilian, & Fegert, 2015).

One way in which the intricacies of this model of a therapeutic milieu may be understood more holistically is through the framework of an optimal healing environment (OHE; Mahoney, Palyo, Napier, & Giordano, 2009). According to Jonas and Chez (2004), an OHE is regarded as an environment in which physical, social, psychological, spiritual and behavioural aspects of health care are centred on stimulation of healing, support and the development of wholeness within a person. Figure 2 provides a visual representation of this framework. As can be seen, the therapeutic milieu as an optimal healing environment comprises of key elements that holistically contribute to a patient's (person) healing (Mahoney et al., 2009).

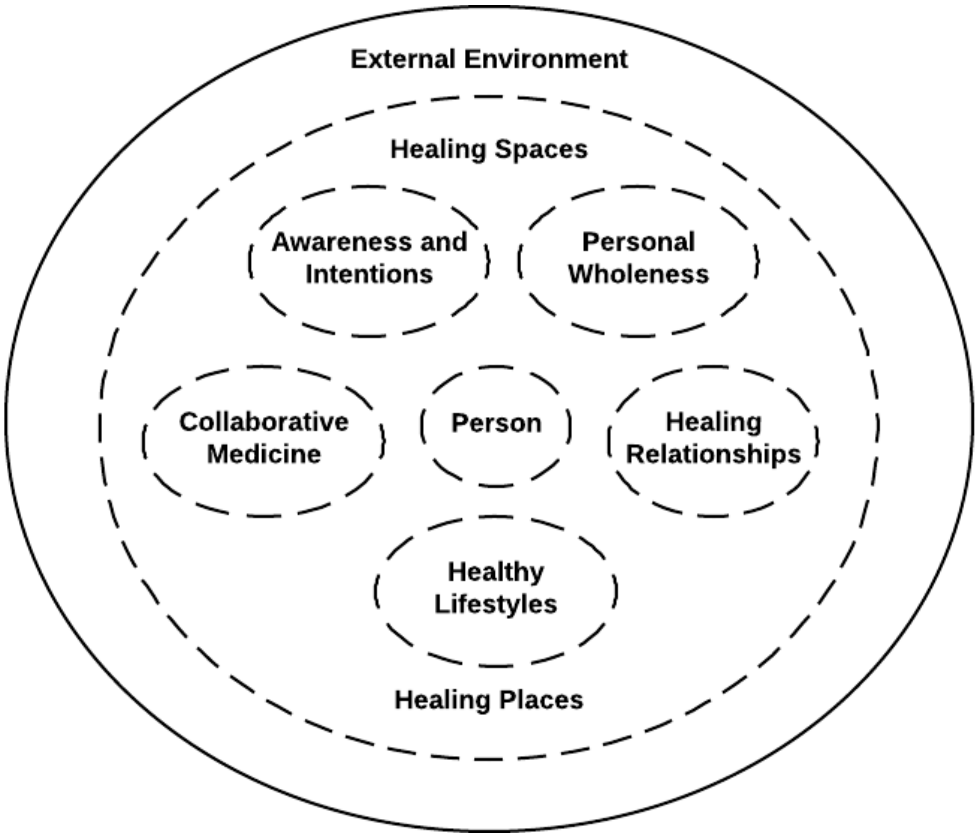


Figure 2. The therapeutic milieu of inpatient psychiatric treatment within the framework of an optimal healing environment. Adapted from "The Therapeutic Milieu Reconceptualized for the 21st Century", by J. S. Mahoney, N. Palyo, G. Napier and J. Giordano, 2009, *Archives of Psychiatric Nursing, 23*(6), p. 425.

In order to develop a greater understanding of the context of treatment and health care within inpatient psychiatric units, I will unpack the elements of a therapeutic milieu environment through the framework of an optimal healing environment depicted in Figure 2. These elements should directly apply to the nature of the activities embedded within the TLC.

Healing spaces

Healing spaces represent aspects of the patient's physical surroundings such as lighting, colour and structural design that help create a more 'homey' and less institutionalized atmosphere (Jonas & Chez, 2004; Mahoney et al., 2009). The TLC provides well maintained and furnished living facilities and recreational spaces (e.g., a safe outdoor area) that caters for the needs of the children who are admitted as they accustom themselves to the milieu environment.

Healing places

Creating and sustaining healing places are reliant upon team leadership, adequate service and evaluation within the unit (Jonas & Chez, 2004; Mahoney et al., 2009). The TLC comprises

of expert and experienced mental health practitioners that lead the unit in the aim to provide top quality psychiatric service that may be reviewed for improvement over time.

Collaborative medicine

The application of collaborative medicine is embodied by the integration of conventional, complementary and alternative therapeutic modalities that not only diversifies treatment but promotes self-recovery in both the lives of the admitted child and his/her parents/guardians/carers (Jonas & Chez, 2004; Mahoney et al., 2009). For example, preliminary social science research has suggested that art therapy and psychotherapeutic relaxation modalities result in short-term reductions in aggressive behaviour in child inpatients (Bornmann, Mitelman, & Beer, 2007; Kapitan, 2012). This has been evidenced in the earlier section on the programme description of the TLC.

Awareness and intentions

In order to develop awareness and healing intention, the conscious commitment of each multidisciplinary team member to know what biological, psychological and social factors contribute to a patient's distress, is needed (Jonas & Chez, 2004; Mahoney et al., 2009). Within inpatient units such as the TLC, this allows all treatment modalities to understand how to enable the patient to improve his/her capacity to manage and change dysfunctional behaviour and experience a more personal wholeness.

Healing relationships

Cultivating healing relationships is elicited by enhancing care, effective communication, empathy, compassion and support between each team member and the patient (Jonas & Chez, 2004; Mahoney et al., 2009). A healing relationship between the patient and the registered psychiatric nurses may be emphasised more within an inpatient setting given that, overall, the nurses spend more time observing and supervising the patient's progression through admission and are responsible for reinforcing adaptive behavioural functioning (Müller & Poggenpoel, 1996). This is particularly the case within the TLC given that, depending on the severity of the children's conditions, a minimum of two nurses are always present attending to their needs and providing core support to the children.

Healthy lifestyles

Finally, instilling healthy lifestyles is represented by enhancing the patient's health habits and daily practices such as his/her diet and level of exercise and relaxation (Jonas & Chez, 2004; Mahoney et al., 2009). Again, this element is largely supervised and facilitated by the psychiatric nurses within the TLC.

Overall, the therapeutic milieu environment has been considered the most important component of an inpatient psychiatric unit (Thompson et al., 2002). Previous research has shown that inpatients admitted into a mental health facility in Canada perceived the therapeutic milieu environment contributed substantially to their improved satisfaction of treatment and their quality of life (Urbanoski, Mulsant, Novotna, Ehtesham, & Rush, 2013). As such, the evidence discussed above appears to coincide with the framework and activities implemented at the TLC which supplement the need for implementing and sustaining a therapeutic milieu environment, particularly for children who are eligible for admission.

Assessing the outcomes of the TLC

As a further part of the literature review, I wanted to locate evaluation research that investigated clear outcomes and/or impacts of child and adolescent inpatient psychiatric units that coincided with those intended from the TLC. After accessing high-quality evaluation databases such as Cochrane Library and J-pal impact evaluation repositories, it is evident that a scarcity of evaluation research, in general, on child and adolescent inpatient psychiatric units exists, both nationally and globally. Nationally speaking, it would make sense for there to be little or no research in this field given that there are only three inpatient psychiatric units established within South Africa, including the TLC which, as mentioned, is the only unit present within the Western Cape.

Outcome evaluations focused on family involvement in the unit

One common aspect of reported child inpatient psychiatric interventions that may fall under the element of the external environment displayed in Figure 1, and is integrated into the programme theory for the TLC, is the role of the family. Positive family involvement and parenting support offered in the treatment plan of a child have been suggested to increase the likelihood that psychiatric inpatient treatment may be effective (Schwenck, Schneider, &

Reichert, 2015). This largely emulates the influence that adaptive parenting approaches and integrated familial relationships have on the development and manifestation of the child's mental health difficulties and conditions (Schwenck et al., 2015). One outcome evaluation study was found that focused on assessing the outcomes of a child mental health unit on these key child and family variables. I will unpack this evaluation study below.

Gavidia-Payne, Littlefield, Hallgren, Jenkins, and Coventry (2003) conducted an outcome evaluation, using a pre-post-follow-up design, with the aim of assessing child, parent and family functioning outcomes as a result of brief admissions to the Statewide Child Inpatient Mental Health Unit (SCIMHU) situated in Australia. Whilst operating within a therapeutic milieu environment, the SCIMHU possessed two key principles for its purpose as a child psychiatric inpatient unit. Firstly, to provide each admitted child and his/her family with comprehensive assessment and support depending on the needs and circumstances of each child and his/her family. Secondly, the unit aimed to bring about sufficient change in a short period of time in order to enable effective treatment to occur. As such, the relevant parents, teachers and patient referrers completed a series of questionnaires that measured changes in the following variables: children's behaviour and functioning; children's health status and treatment outcomes; children's self-concept; early detection of dysfunctional parental disciplining; parenting self-esteem; depressive symptomatology in adults; and family functioning on several dimensions (e.g., responsiveness). The SCIMHU was found to have benefits for both parents and children. In terms of the parents, results indicated significant improvements in parenting practices; parenting competence and self-efficacy; and reductions in parental depression. In terms of the children, significant improvements were only detected in the child's behaviour and functioning. The results suggest that units which integrate both child- and parent-level goals may achieve intended outcomes.

Following these findings, there were two key constraints of the evaluation study discussed above. Firstly, with specific regard to the length of child admission and treatment, the programme established at the SCIMHU would be argued to have been too short (i.e., lasting from four to six weeks) (Gavidia-Payne et al., 2003). As such, what distinguishes the SCIMHU from the TLC in terms of length of admission and treatment is that the former has a programme that is set in its duration, unlike the latter which will admit eligible children whose length of

admission and treatment will depend on the severity of their conditions and how well these conditions improve over time. The TLC's longer duration of admission and treatment allows for a focus on ensuring that improvement in the child's conditions, relations with their family and support for adaptive parenting approaches are being achieved.

The second key constraint highlighted was the fact that the majority of the children admitted only had single parents that were caring and looking after them (Gavidia-Payne et al., 2003). Larger amounts of pressure and anxiety are experienced by single parents who try, not only to comprehend the mental health conditions of their child but to cope and help manage their child's and even their own difficulties as a parent (Schwenck et al., 2015). This constraint may provide a reason for the lack of significant improvement in overall family functioning. Unlike the SCIMHU, the majority of children who have been admitted into the TLC over the past three to six years have either had two biological parents or one biological and one step-parent caring for them.

Two similar outcome evaluations to the above study by Gavidia-Payne et al. (2003) were conducted on child and adolescent inpatient psychiatric units – one situated at the Dokuz Eylül School of Medicine in Turkey (Güvenir, TAŞ, & Özbek, 2009) and the other situated at the Kohnodai Hospital in Japan (Setoya et al., 2011). I will now unpack the findings of both of these outcome evaluations conducted.

Outcome evaluations focused on psychological and social functioning

The first outcome evaluation study assessed the effectiveness of child and adolescent inpatient psychiatric treatment established at the Dokuz Eylül School of Medicine in Turkey retrospectively from 2006 to 2008 (Güvenir et al., 2009). The researchers measured key outcome variables of psychological and social functioning and symptom severity in admitted child and adolescent patients (Güvenir et al., 2009). Incorporated into the measurement procedures were clinicians' assessment of clinical improvement of a patient's academic or vocational motivation over-and-above their individual difficulties; family relationship status; and social life. Importantly, the findings illustrated that psychotropic medication monitored by child and adolescent psychiatrists was associated with improvement in the outcomes mentioned but was dependent on the severity of the patient's conditions. Furthermore, 46% of past child patients admitted to the Dokuz Eylül School of Medicine inpatient unit reported partly better

improvements in academic or vocational motivation. Arguably, this last finding suggested is particularly relevant, not only to special needs education modalities that are characteristic to child and adolescent inpatient psychiatric units in general - but seemingly for the TLC. Despite not assessing improved academic performance, motivation for academic performance serves as a plausible intermediate outcome for the educational section of treatment provided at the TLC. It would be beneficial for subsequent research to investigate factors that may be associated with academic performance and individual motivation for it.

The second outcome evaluation study conducted on the child and adolescent inpatient psychiatric unit situated at the Kohnodai Hospital in Japan, looked at measuring outcomes of psychiatric treatment by primarily focusing on a patient's a) psychological and social functioning, and b) adaptive functioning in accordance with emotional and behavioural problems at admission (baseline) and subsequently at discharge (Setoya et al., 2011). What this evaluation further investigated were factors that were that associated with improvement in the above outcomes. Based on the outcomes measured, significant improvements were reported in all domains of child and adolescent functioning, such as symptom severity and aggressive behaviour. On the contrary, no significant improvements were detected for areas in social, thought and attention problems that were specific to the patient's conditions (Setoya et al., 2011). Expectedly, the nature of a patient's conditions served as a factor associated with more or less improvement. Expectedly, the nature of a patient's conditions served as a factor associated with more or less improvement. Patients with Schizophrenic symptoms were less likely to show progress.

Impact evaluations focused on behavioural management and adaptive modification

For this final section on assessing the outcomes of the TLC, I will focus on gauging with an impact evaluation conducted by (Dean, Duke, George, & Scott, 2007) on a behavioural management programme for a child and adolescent inpatient psychiatric unit.

As discussed, behavioural management and adaptive modification play a fundamental role in the provision of quality inpatient psychiatric care for children and adolescents, given the prevalence of aggressive episodes and threats to personnel and individual safety experienced (Phillips, Stargatt, & Fisher, 2011; Yampolskaya, Mowery, & Dollard, 2013). Dean et al. (2007) aimed to evaluate the impact of a behavioural management programme that was integrated into a

multidisciplinary child and adolescent inpatient psychiatric, tertiary care unit. The programme was implemented in order to reduce the frequency of aggressive behavioural incidents by child inpatients by focusing on a) enhancing behavioural management skills, particularly for the nursing sector; b) implementing individualised management plans; and c) reinforcing standardized appropriate behaviours in response to dysfunctional behaviours displayed. By measuring retrospective clinical records six months prior to and post-intervention, it was found that not only were aggressive behavioural incidents significantly reduced over this timeframe specified but that few procedures of restraint and seclusion (e.g., time out) were utilised. This latter finding may be argued to be a key indicator of successful behavioural management and gradual modification being achieved without the use of restraint and seclusion procedures, which (Valenkamp, Delaney, & Verheij, 2014) has suggested, may contribute to the worsening of an admitted child's mental health conditions. Valenkamp et al. (2014) argue that the process itself of assisting the child into a secure and safe time-out room may make him/her feel isolated and neglected from the staff members and peers, depending on the child's specific conditions.

Critique of the outcome and impact evaluation studies

The outcome and impact evaluation studies discussed in the above sections provide us with an indication of success and significant improvement in key areas of child mental health difficulties. However, without an equivalent control group, there are limits to the conclusions that can be drawn, particularly those that attribute changes experienced by admitted children as a result of the treatment offered at the specific psychiatric units (Boege et al., 2015). As expressed by Gavidia-Payne et al. (2003), much of this difficulty stems the shortage of sample units available (i.e., number of patient admissions); the differences in treatment between existing milieu environments; and the fact that the patients who are admitted possess an array of diverse conditions and demographics that make establishing equivalence particularly difficult.

Overall, patients with poor familial integration and lack of involvement in treatment were found to present more severe mental health problems and therefore required a longer and more complex treatment plan, even post-discharge (Setoya et al., 2011). The outcomes measured by Setoya et al. (2011) in their evaluation that focus on the well-being of psychological and social functioning in the admitted children appear to resonate with those of the TLC. This resonation particularly coincides with many of the short- and long-term outcomes expected from the core

psychiatric treatment modalities implemented by the clinical psychologist; child and adolescent psychiatrist; social worker; and occupational therapist at the TLC. Furthermore, the outcomes achieved from the behavioural management and modification procedures investigated by Dean et al. (2007) appear to coincide with those elicited by the behavioural management and modification framework embedded in the TLC. The outcomes, such as reduced aggressive behavioural incidents, are largely improved by positive reinforcement of learning new adaptive behaviours by the psychiatric nursing staff. As such we are able to conclude that the activities of the TLC and the expected outcomes linked to these are feasible.

Directions for current evaluation research and concluding remarks

It is clear that not only are there very few evaluation studies overall that have been conducted on child and adolescent inpatient psychiatric units but that few studies have evaluated the fidelity of the services and treatment implemented within child inpatient psychiatric units particularly against internationally recognised standards. In other words, to what extent these units implement services and treatment according to what they have planned.

Furthermore, in line with supporting the promotion of quality treatment and mental health service in child inpatient psychiatric units, the majority of programme evaluation studies conducted globally represent accessible reports that follow the scopes of outcome or impact evaluations, not process/implementation evaluations. As part of the establishment of the National Health Insurance (NHI) Fund in 2012, whose mandate is to provide all South Africans with quality and affordable health services in order to meet their respective needs (National Department of Health, 2011), the TLC undergoes annual peer reviews of its institution and its operations in order to prepare for the national audit. What this process entails is reviewing all documentation and operations of patient care, policies, quality assurance, facilities and equipment and hygiene (to name a few) against the country's National Core Standards (NCS), which apply to both the public and private sector (National Department of Health, 2011). As such, health care providers, like the TLC, are the primary audience of the NCS as they are required to comply with the established standards with the broader goal possessing a more responsive health system that improves patient satisfaction of care leading to a better quality of life.

Not only can it be argued to be important to comply with locally established standards, but also international standards of service quality. As emphasised by head mental health professionals of the TLC, critiquing the TLC unit against international benchmarks allows them to see how the service quality of the unit favours against international standards of service quality, especially as the TLC is the only child inpatient and day-patient psychiatric unit within the Western Cape. One international platform that was deemed by the head psychiatrist as both relevant and useful for evaluating programme implementation at the TLC is the Quality Network for Inpatient Child and Adolescent Mental Health Service (QNIC). The QNIC is a network that aims to promote and improve the implementation quality of child and adolescent inpatient psychiatric care units through a system of review against recognised QNIC unit standards (Thompson & Clarke, n.d.), much like the NCS within South Africa. The QNIC unit standards are informed by new literature reviews and are mapped against the Care Quality Commission (CQC), You're Welcome (YW) and Monitor Quality Criteria (M).

Scope for current evaluation research

The evaluator was asked to benchmark the TLC against the QNIC specifically. As such an implementation evaluation was planned. Programme implementation evaluations involve assessing a programme's performance in terms of service utilisation and programme organisation (Rossi, Lipsey, & Freeman, 2004). They focus on examining the extent to which the specified target population/beneficiaries are receiving the intended services of the programme and on assessing and comparing whether the programme's activities are being implemented as planned (Rossi et al., 2004). In the context of the TLC, the implementation evaluation assessed and critiqued the child inpatient psychiatric unit's standards of mental health service against internationally recognised unit standards of service quality.

Implementation evaluation questions

Given the extensiveness of the QNIC checklist of international standards, relevant standards per subcategory for the TLC were prioritised and highlighted for the formulation of the implementation evaluation questions. The primary implementation evaluation question was:

Do the TLC's implementation and service delivery conform to international best practice for inpatient Child and Adolescent Mental Health Service (CAMHS)?

Questions related to the environment and facilities:

1. Are the premises and the necessary facilities and resources of the TLC inpatient unit designed and managed to ensure that the inpatient or day-patient's rights, privacy, and dignity are respected?
2. Does the TLC inpatient unit provide a safe environment for both staff and patients?

Questions related to staffing and training:

3. Are the staff of the multidisciplinary team provided with effective support and training programmes?
4. Are there a sufficient number of nursing staff to safely meet and support the needs of the admitted inpatients or day-patients within the unit at all times?

Questions related to access, admission and discharge:

5. Is there equity and diversity of access to the TLC in terms of a child's ethnicity, social status, physical health and location of residence?
6. Are plans established to outline the continuing needs of the patient post-discharge?

Questions related to care and treatment:

7. Are admitted inpatients or day-patients able to continue with their education at their academic level within the unit?
8. To what extent are admitted inpatients' and day-patients' and their respective parents'/carers' views on their care and treatment taken into account?

Questions related to information, consent and confidentiality:

9. Is appropriate confidentiality and consent from parents/carers ensured in order to conduct the required examination and treatment on an admitted inpatient and day-patient?

Questions related to the rights and safeguarding of children:

10. Are the staff members operating within a safe, ethical and appropriate legal framework in relation to the use of behavioural management procedures when helping patients manage difficult emotions and behaviours?

Questions related to clinical governance:

11. Is information collected on clinical matters disseminated accordingly for all staff members to learn from?
12. Does the TLC unit implement a comprehensive range of policies and procedures that provide a role for service that is set in a context of four-tier CAMHS strategy?

Chapter 2: Method

An important aspect of evaluation research is formulating an evaluation design that can be duplicated and have a real-world effect on the specific programme under evaluation. The following sections provide the design and method of the implementation evaluation undertaken in this research.

Research Design of the Implementation Evaluation

For the implementation evaluation, a descriptive research design was employed. According to Posavac (2015), this type of design is embodied by an in-depth description of phenomena, which may serve a multitude of purposes, such as a) to help illustrate whether a programme is operating as planned; b) to help clarify a programme's processes and to what extent the objectives of their services are being met; and c) to help provide feedback about the services that the programme offers to its primary and secondary beneficiaries. Unlike exploratory studies, descriptive studies employ data-gathering techniques which tend to be more precise, with a specific focus on what is being studied (Johnson, Onwuegbuzie, & Turner, 2007; Posavac, 2015).

As such, this descriptive research design was suitable for the implementation evaluation for two reasons. Firstly, measuring the international unit standards within the QNIC against the TLC enabled a focused overview on the extent to which the programme is offering and implementing its multitude of mental health care and support to both the children who are admitted and their respective parents/carers. Finally, unit standards that fall within the specified categories that are not being satisfied sufficiently may highlight areas of service quality and integrity that may require improvement.

Participants

The individuals that were selected and recruited to participate in the implementation evaluation comprised of individuals who are currently employed and have important contributions as staff/team members of the TLC's multidisciplinary team. These core individuals included the a) head child and adolescent psychiatrist of DCAP a) head child and adolescent psychiatrist of the TLC b) registered clinical psychologist; c) operational manager; d) two experienced and long-term members of the psychiatric nursing team; e) social worker; f) TLC

primary school teacher; and g) TLC primary school principal teacher. These respective participants represent individuals who are in positions to direct and provide credible documentation, information and experiences to establish the extent to which the international unit standards of the QNIC are being met by the TLC based on each of the seven categories. Despite having the capacity to respond to specific unit standards, parents and/or carers were not included as data providers in this study. The evaluator was not given permission to contact this sub-group of stakeholders. The multidisciplinary team did, however, explain that parental and/or carer feedback would be incorporated in successive studies to the current one.

Recruitment and sampling

The recruitment of multidisciplinary staff/team members of the TLC into the study was not a challenging process given that I, the researcher, am currently employed as the class assistant for the primary schooling component of the therapeutic milieu environment established within the unit. From this position of involvement, I was able to contact and/or approach the relevant staff/team members for recruitment of their participation in the study.

I recruited my participants using the method of non-probability purposive sampling in which participants are selected on the basis of pre-selected criteria. This sampling method is best suited for the current evaluation research which does not aim to generalise findings to a homogenous population. The only pre-selected criteria that served as a basis for participant recruitment is the position of employment in which the staff member of the multidisciplinary team possesses. However, with specific regards to the selection of two experienced nurses for participation, these nurses needed to have at least one years' worth of experience specifically at the TLC. By setting this minimum of one years' experience, it allowed the researcher to recruit nursing staff members who had sufficient understanding of the TLC unit and its services provided to the children admitted within it.

The specific type of purposive sampling I employed is known as heterogeneity sampling (Trochim & Donnelly, 2005). The rationale for using heterogeneity sampling in this evaluation is that, unlike homogenous sampling, the participants I recruited possessed, not only, varying individual traits, characteristics and demographics, but experiences of a) their employment and position as a team member of the TLC (i.e., the staff); and b) their support received from and

input given into the service quality of the TLC and its multidisciplinary team members treatment of the children.

Measures

Each standard description of the QNIC was targeted for measurement. The entire data collection tool consists of distinct categories integrated into one. The format itself is loosely adapted and developed from the You're Welcome resource accreditation pack established by the Department of Health and You're Welcome Leads in the East Midlands Region which was originally implemented for Derbyshire County in England. This tool is available on www.cyphderbyshire.co.uk.

Each of the 324 unit standards is measured according to a Likert rating scale (Kaplan & Saccuzzo, 2013). This rating scale consists of 3 Likert-style options with 1 being (*not met*); 2 being (*partially met*); and 3 being (*fully met*). This format indicates the participants' degree of agreement regarding the extent to which each standard is satisfied by their facility (Kaplan & Saccuzzo, 2013).

In addition to the rating format, included in the measurement for each standard was a section in which participants are asked if they wanted to provide reasoning for their response (qualitative section) as well as can provide any additional evidence of the standard being met (e.g. written policy or Standard Operating Procedure). The participants' open-ended responses to their degree of agreement enriched their response by providing their own personal perspectives and experiences within the TLC and the significance that the particular aspect addressed in each standard has. By allowing the participant to indicate whether or not any evidence of the standard being met is available supplemented and added more reliability to their responses provided on the Likert-style options.

Not every standard developed by the QNIC could be included for assessment. In conjunction with engagement with key stakeholders of the TLC, individual unit standards were selected based on their applicability and relevance to the context of the TLC. Specifically, a total of five unit standards were selected for exclusion from the assessment. They consist of unit standards 1.2.2; 6.1.1; 6.1.2; 6.1.3; and 6.3.1. For a description of these selected unit standards and the reasoning for their exclusion, see Table 3.

Table 3

Excluded QNIC Unit standards

Category	Subcategory		Standard Description	Reason for Exclusion
Environment and Facilities	1.2 Children's units and adolescent units are separate from adult units	.2.2	When a unit is on the same site as an adult unit, there are policies and procedures in place to ensure young people are not using shared facilities at the same time as adults; a safeguarding policy is in place to allow safe access to wider grounds within the unit Ref 50, pg133: 'We recommend that the goal of separate adolescent provision from children and adults should be explored by policy makers and considered actively by management in all hospitals.'	The TLC, as distinct unit falling under the Division of Child and Adolescent Psychiatry, represents a satellite campus that only admits children between the ages of six and twelve and therefore does not apply to adults.
Young People's Rights & Safeguarding Children	6.1 If a young person is detained under the Mental Health Act (MHA), the legal authority for admission and treatment is clear	6.1.1	The MHA status (detained and informal) for each young person is recorded in their notes.	The children who are admitted into the TLC unit do not fall under any local legislation (e.g., Children's Act) for detainment and therefore would not require access to a managers hearing or advocacy service.
		6.1.2	Detained young people are given verbal and written information on their rights under the Mental Health Act (or equivalent) and this is documented in their notes	
		6.1.3	Young people are provided with information about their rights to access a mental health tribunal and/or managers hearing. Ref 36, pg. 51: 'Hospital managers have the primary responsibility for seeing that the requirements of the MHA 1983 are follows. These include the right to apply to (and be legally represented at) a Tribunal for a review of the person's detention.' Ref 36, pg. 74: 'In relation to children and young people who are detained under the MHA 1983, hospital managers should ensure that they are made aware of their right and given assistance in applying to hospital managers' hearings and Tribunals and helped to obtain legal representation at an early stage	
	6.3 Young people and their parents/carers are informed about how to make complaints and seek independent advice	6.3.1	All young people have access to an advocacy service, including IMHAs (Independent Mental Health Advocates) for those detained Ref 13, pg. 107: 'Details of local organisations providing independent advocacy are displayed in the establishment.'	

Data Collection Tool

Each edition of the QNIC checklist ensures that, not only are new standards included or existing standards revised but that the standards are up to date and accurate. The standards are divided into seven categories: environment and facilities; staffing and training; access, admission and discharge, care and treatment; information, consent and confidentiality; young people's rights and safeguarding children; and clinical governance (Thompson & Clarke, n.d.). The standards within each section are separated as either representing type one, type two or type three standards.

Type 1 represents standards in which if failure to meet them is incurred, it would result in a significant threat to the safety, rights and/or dignity of the patient and would breach the law (Thompson & Clarke, n.d.). Type 2 represents standards that an inpatient psychiatric unit would be expected to meet (Thompson & Clarke, n.d.). Finally, type 3 represents standards that an exceptional inpatient psychiatric unit should meet or standards that are not the direct responsibility of the unit itself (Thompson & Clarke, n.d.).

Given that the QNIC is not a psychological scale, the validation of the checklist is not well documented. The only evidence of this tool's validation is presented in a final report conducted by Craig, Halvey and Johnstone (2016) which assessed the unit standards across multiple child and adolescent psychiatric units in the UK. From this research, they were able to conclude that the standard range for Type 1 standards being met is was between 90 – 95%. Type 2 standards were found to record between 83 – 88% met and type 3 standards were found to record between 78 – 85% met.

Procedure

Approval to work with the TLC unit for the purpose of this evaluation research was granted by both the head child and adolescent psychiatrist and clinical psychologist of the TLC unit. The permission letter found in Appendix A was only formally signed once I have received ethical approval from the appropriate departments at the Red Cross War Memorial Children's Hospital.

Once approval for the proposed evaluation had been granted from the TLC, I obtained ethical approval for the research from the Commerce Faculty's Ethics in Research Committee.

Following this ethics application, approval was sought from the Health Science's Ethics Committee. This was necessary because the evaluation was being conducted in a medical facility which by their definition makes the research health-related. Following this approval, an application was sent to the Red Cross War Memorial Children's Hospital Ethics Committee. These approval processes took close to three months.

Before distributing the unit standards checklist tool I, provided a cover letter to each participant that contained: a) the description and purpose of scope of the process evaluation of the TLC; (b) how confidentiality of data would be secured; (c) the voluntary nature of participation; and (d) the fact that there would be no penalties for withdrawal from participation. This consent letter can be found in Appendix B.

For the distribution of checklists to the respective TLC staff/team members, I approached each participant at the TLC to inform them about the study and then emailed them a link to the checklist. In order to answer and clarify any inconsistencies and/or uncertainties by the participants, I ensured that I was readily available, both via email and in-person, to answer any questions and assist with the data provided. Due to the fact that the full checklist contained categories with unit standards that were not applicable or knowledgeable to the two participants from the schooling component, these participants only responded to unit standards that were applicable to schooling within the unit. The participants completed the formulated checklist over a period of four to five weeks. Once completed, the checklist, with their responses, was returned to me for review and reporting according to descriptive research methods which will be addressed in the next section.

Data Analysis

In line with descriptive research designs, the questionnaire and checklist provided to and completed by the participants were reported using descriptive and frequency statistics. Importantly, the qualitative responses provided by participants helped interpret why it is that a standard may or may not have been met. These qualitative responses were used as direct quotations in order to support the descriptive results recorded. This is common practice when using this checklist. An example of the use of qualitative responses to support the descriptive results can be seen in Figure 3, which was taken from a final report of the QNIC unit standards against internationally recognised CAMHS units from September 2015 – May 2016.

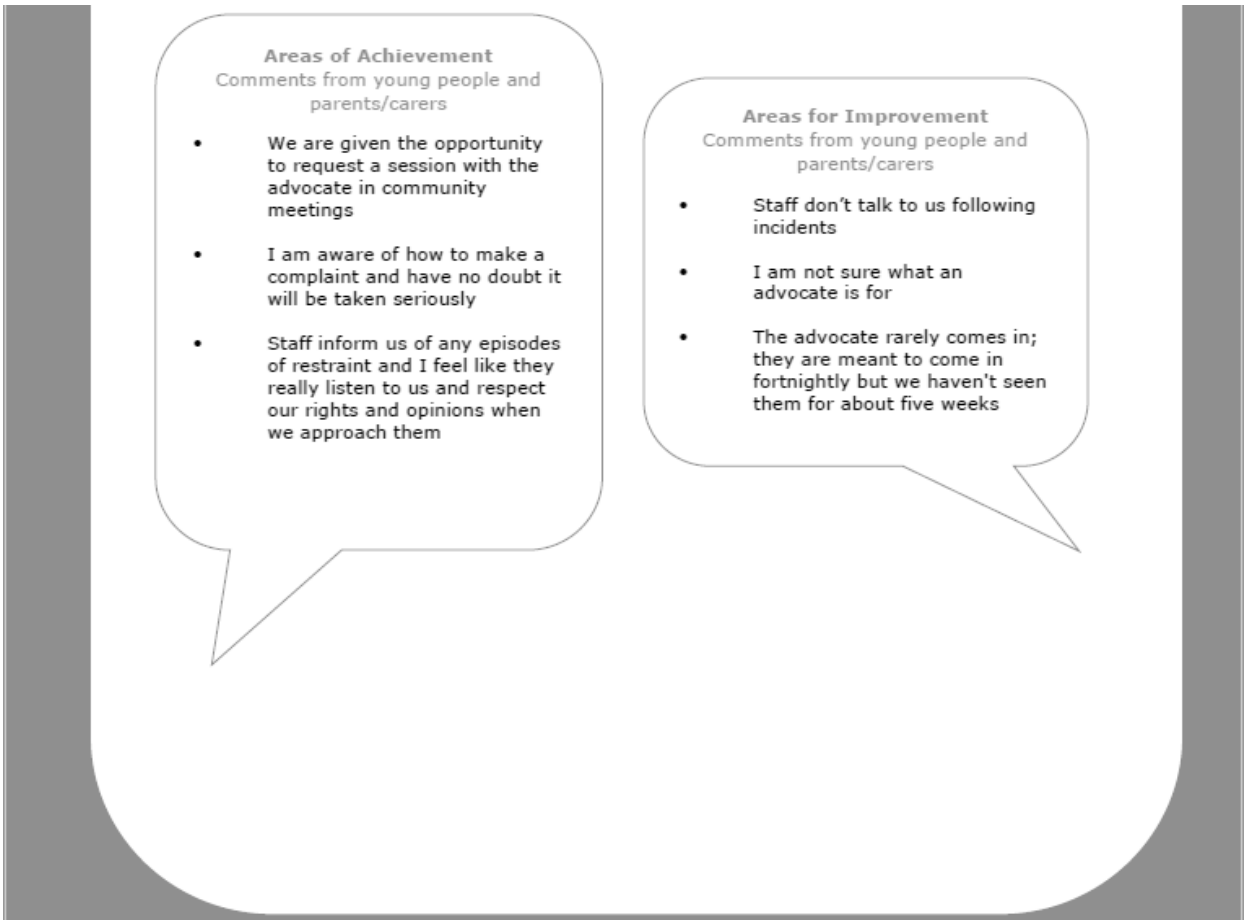


Figure 3. Quotations from participants used to support descriptive results recorded. Adapted from "Quality Network for Inpatient CAMHS Annual Report (QNIC)" by H. Craig, J. Halvey and T. Johnstone, 2016, *Royal College of Psychiatrists*, p. 31.

Ethical considerations

To ensure that the proposed research met the appropriate ethical requirements, I obtained ethical clearance as detailed above.

With regards to the treatment of participants in both quantitative and qualitative research, certain ethical considerations may be of significance, particularly those that apply to the investigation of sensitive topics (Willig, 2013). The next section will discuss these relevant ethical considerations.

Harm to participants

As a researcher, I had an ethical obligation to prevent participants from experiencing any harm which may be embodied by threats to their personal safety, experiencing emotional and/or psychological distress or the damaging of their reputation (Willig, 2013). There was no expectation that participants would be harmed or experience distress by taking part in this research.

Violation of privacy and confidentiality

According to Willig (2013), privacy may be recognised as an individual's right to decide, where, when and to whom they want their experiences to be revealed. The identities of all participants who proceeded with the data collection process were safeguarded through the exclusion of their names. No pseudonyms were created. Furthermore, if the participants disclosed their position of employment within their qualitative comments made on the questionnaire, I altered their specific position of employment to a generic position within the TLC multidisciplinary team. As such, I labelled it as 'multidisciplinary team member' in order to protect their identity. Moreover, I was the one to paraphrase all the personal and experiential responses which simplified any further issues of confidentiality. All responses were safely stored away in an electronic database that was protected by password access.

Deception of participants

Deception is defined as any means of intentionally misrepresenting or misconstruing facts in such a way that participants may believe that which is not true (Willig, 2013). Participants were not deceived regarding any aspect of the evaluation process.

Chapter 3: Results

The following chapter presents the results of how successfully the TLC complies to the standards contained in the Quality Network for Inpatient Child and Adolescent Mental Health Service (QNIC). The results of this chapter are reported using descriptive and frequency statistics, along with the qualitative comments that were provided by the data providers. To remind the reader, the QNIC standards are divided into seven categories pertaining to the quality of service and implementation provision at inpatient units/facilities. Within the seven categories, there are sub-categories. These were detailed in the previous chapter.

To remind the reader, not only does each category of the QNIC have sub-categories, but each unit standard is either deemed a Type 1, Type 2 or Type 3 unit standard. Type 1 unit standards are those in which if failure to meet them is incurred, it would result in a significant threat to the safety, rights and/or dignity of the patient and would breach the law (Thompson & Clarke, n.d.). Type 2 unit standards represent standards that an inpatient psychiatric unit would be expected, and not required, to meet (Thompson & Clarke, n.d.). Type 3 unit standards represent those that an exceptional inpatient psychiatric unit should meet or standards that are not the direct responsibility of the unit itself (Thompson & Clarke, n.d.). It then makes sense that when rating a unit on their overall effectiveness, one would want to see that all Type 1 unit standards are met, most of the Type 2 unit standards are met, and some Type 3 are met. It is for this reason that the results are presented per category but also by type of unit standard. For those that prefer to see the standards presented chronologically, this has been included in Appendices C to I.

Category 1: Environment and Facilities

The Environment and Facilities Category refers to aspects of the child inpatient psychiatric unit such as how well the facilities are designed and maintained in that way a) protects the patients' and staffs' dignity and privacy, and b) provides a safe environment that is able to deal with emergencies accordingly. There are a total of 55 unit standards for this category. The following stakeholders (n=7) were asked to provide input on the TLC's environment and facilities in relation to the QNIC standards: three members of the psychiatry department; one member of the psychology department; and three members of the nursing

department. The results of the type 1, type 2 and type 3 environment and facilities unit standards are presented in the next section.

Type 1 Unit Standards: Category 1

Table 4 presents the standards of Category 1 (i.e., environment and facilities at the TLC) that are identified as Type 1 (n=25). Furthermore, the table also displays the following: the rating provided by each of the responding stakeholders; the mode (i.e., most frequently selected response) of each standard assessed; and a summary of the corresponding qualitative reasoning provided by the respondents for their rating choice. This summary was written by the evaluator after reviewing the individual qualitative responses (the individual responses of each stakeholder can be seen in Appendix C). Ratings for each unit standard were coded as follows: not met (1); partially met (2); or fully met (3).

Table 4

Type 1 Standards for the Environment and Facilities (n = 25)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
1.1.2	All rooms are kept clean.	One		2		3	Overall, cleaning staff and housekeeping regularly ensure that cleaning schedules of the rooms are adhered to on a daily basis despite some areas requiring more attention and upgrading such as the furniture.
		Two			3		
		Three			3		
		Four			3		
		Five			3		
		Six			3		
		Seven			3		
1.1.8	Young people are able to access safe outdoor space every day where clinically appropriate.	One			3	3	Access to safe outdoor space forms part of the TLC inpatient programme where access is on a daily basis dependent on clinical and weather factors. There is sufficient exercise space for the children to engage with which is always supervised by nursing staff.
		Two			3		
		Three			3		
		Four			3		
		Five			3		
		Six			3		
		Seven			3		
1.1.12	In Unit/units which have a seclusion room, it must meet the following requirements: • The room must allow for clear observation; • Be well insulated and ventilated; • It must have direct access to toilet/washing facilities; • The room must be safe and secure – it does not contain anything that could be potentially harmful; • It must include a means of two-way communication with the team; • It should have a clock that young people can see.	One		2		2	Overall, by definition, the TLC does not possess a designated seclusion room based on the age of the children admitted. Instead, two Time Out rooms are situated which satisfies some of the aspects listed. The space is safe and secure for the children when they are feeling severely distressed and uncontained as the staff members are able to observe and communicate with them appropriately as means to calm them down.
		Two			3		
		Three		2			
		Four	1				
		Five		2			
		Six	1				
		Seven		3			

Table 4 Continued

Type 1 Standards for the Environment and Facilities (n = 25)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
1.1.16	Young people use mobile phones, computers, cameras and other electronic equipment on the Unit, which provide access to the internet and social media. This is subject to risk assessment and is in line with local policy.	One	1			1	The general agreement is that children admitted are not permitted to access electronic devices or the internet according to policy at the TLC. The children are identified as too young with potential for risk should use be available.
		Two	1				
		Three	1				
		Four	1				
		Five			3		
		Six	1				
		Seven		2			
1.1.17	Each young person has the educational materials required for continuing with their education.	One		2		3	Overall, educational materials and resources required for the children's academic progression and support are established by the TLC. Children receive special, individualised and group attention with a particular focus on their difficulties within school aligned with the CAPS Schooling System. There are concentrated subjects which accommodate the children's Grade level from R to 7.
		Two			3		
		Three		2			
		Four			3		
		Five			3		
		Six			3		
		Seven			3		
1.2.1	There is a visiting policy which includes procedures to follow for specific groups including: • Children; • Unwanted visitors (i.e. those who pose a threat to young people or to staff members).	One		2		2	A visiting policy is established at the TLC. There is uncertainty whether it is written or not. Visitation occurs on Wednesday afternoons and on weekends when a child stays in compared to the main hospital which has daily visiting hours. There appears to be support from social workers and social development to sustain appropriate visitation for the children.
		Two		2			
		Three			3		
		Four		2			
		Five			3		
		Six		2			
		Seven			3		

Table 4 Continued

Type 1 Standards for the Environment and Facilities (n = 25)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
1.3.1	All young people's information is kept in accordance with current legislation. *Guidance*: *Staff members ensure that no confidential data is visible beyond the team by locking cabinets and offices, using swipe cards and having password protected computer access.*	One	1			2	Overall, documents containing the children's information are predominantly stored away in filing cabinets and not electronically. Rooms with access to these cabinets are not locked routinely with no swipe card or password control. It is mainly accessed by nursing and clinical staff.
		Two		2			
		Three			3		
		Four		2			
		Five		2			
		Six	1				
		Seven			3		
1.3.2	The environment complies with current legislation on disabled access. *Guidance: Relevant assistive technology equipment, such as hoists and handrails, are provided to meet individual needs and to maximise independence*.	One		2		2	Overall, the TLC is not fully compliant with legislation on disabled access to the unit. A ramp is present by entrance for general access but no disabled parking is designated nor are the bathrooms and toilets accessible for those with physical disabilities. The structural layout of the unit was not designed for those with disabilities.
		Two		2			
		Three		2			
		Four		2			
		Five	1				
		Six	1				
		Seven		2			
1.3.4	Young people have separate bedrooms, toilets and washing facilities, split according to self-identified gender. Young people do not pass through areas occupied by members of the opposite sex at night unsupervised to reach the toilet and/or washing facilities.	One	1			1	Overall, the layout of the TLC unit does not cater for self-identified gender in terms of the bathroom, toilet and washing facilities (i.e., these are instead shared) but is able to accommodate gender specific bedrooms depending on the ratio of children according to the gender.
		Two	1				
		Three		2			
		Four	1				
		Five	1				
		Six	1				
		Seven		2			

Table 4 Continued

Type 1 Standards for the Environment and Facilities (n = 25)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
1.3.8	The unit has a designated room for physical examination and minor medical procedures.	One			3	3	Accordingly, there is a fully equipped clinic room and examination room which allow for minor medical procedures and examinations. Blood samples taken need to be transported to the main hospital.
		Two			3		
		Three			3		
		Four			3		
		Five			3		
		Six		2			
		Seven			3		
1.3.11	Young people can make and receive telephone calls in private, where risk permits.	One	1			2	Children are allowed to receive phone calls from parents/carers for a sanctioned period of time to accommodate other children respectively. These phone calls are not fully in private, however, as they are supervised by nursing staff.
		Two		2			
		Three			3		
		Four		2			
		Five		2			
		Six	1				
		Seven			3		
1.3.15	Young people are supported to access materials and facilities that are associated with specific cultural or spiritual practices, e.g. covered copies of faith books, access to a multi-faith room.	One	1			2	Overall, the TLC does not have a designated multi-faith room available. Children are, however, permitted and encouraged to request cultural and/or spiritual material usually under the guidance of their parents/carers based on their age.
		Two		2			
		Three		2			
		Four		2			
		Five	1				
		Six	1				
		Seven		2			

Table 4 Continued

Type 1 Standards for the Environment and Facilities (n = 25)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
1.3.16	Young people can wash and use the toilet in private, unless risk assessment deems they require constant observation.	One			3	3	Overall, standard practice states that washing and the use of the toilets must be done in private. However, based on clinical risk assessment, staff may need to observe and supervise a child appropriately as to not put the child or others in harm's way.
		Two			3		
		Three			3		
		Four			3		
		Five			3		
		Six		2			
		Seven			3		
1.3.16*	Staff members respect the patient's personal space, where risk permits e.g. by knocking and waiting before entering their bedroom.	One	1			3	Overall, the children's personal space is well respected by staff members who observe and supervise them. As stated previously, the extent of observation and supervision is dependent on prior clinical risk assessment.
		Two			3		
		Three			3		
		Four		2			
		Five			3		
		Six	1				
		Seven			3		
1.3.16*	Laundry facilities are available.	One		2		2	An electric washing machine is available for use but no area for drying purposes is designated. These facilities are largely utilised by nursing and cleaning staff.
		Two			3		
		Three		2			
		Four			3		
		Five			3		
		Six		2			
		Seven		2			

Table 4 Continued

Type 1 Standards for the Environment and Facilities (n = 25)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
1.3.16	Young people can wash and use the toilet in private, unless risk assessment deems they require constant observation.	One			3	3	Overall, standard practice states that washing and the use of the toilets must be done in private. However, based on clinical risk assessment, staff may need to observe and supervise a child appropriately as to not put the child or others in harm's way.
		Two			3		
		Three			3		
		Four			3		
		Five			3		
		Six		2			
		Seven			3		
1.3.16*	Staff members respect the patient's personal space, where risk permits e.g. by knocking and waiting before entering their bedroom.	One	1			3	Overall, the children's personal space is well respected by staff members who observe and supervise them. As stated previously, the extent of observation and supervision is dependent on prior clinical risk assessment.
		Two			3		
		Three			3		
		Four		2			
		Five			3		
		Six	1				
		Seven			3		
1.3.16*	Laundry facilities are available.	One		2		2	An electric washing machine is available for use but no area for drying purposes is designated. These facilities are largely utilised by nursing and cleaning staff.
		Two			3		
		Three		2			
		Four			3		
		Five			3		
		Six		2			
		Seven		2			

Table 4 Continued

Type 1 Standards for the Environment and Facilities (n = 25)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
1.4.1	The team keeps medications in a secure place, in line with the organisation's medicine management policy.	One			3	3	The TLC does have a designated clinic room where all medications are securely kept and locked for staff access only according to hospital policies.
		Two			3		
		Three			3		
		Four			3		
		Five			3		
		Six			3		
		Seven			3		
1.4.2	Entrances and exits are designed to enable staff to see who is entering or leaving and if required CCTV is used to achieve this.	One		2		3	Overall, there are CCTV cameras positioned along with the monitoring and guard of security guards who are responsible for staff members, patients, public safety and entrance and exit from the unit. However, there are no specific guards to man exit and entrance onto the overall grounds.
		Two			3		
		Three			3		
		Four		2			
		Five			3		
		Six	1				
		Seven			3		
1.4.3	There are clear lines of sight to enable staff members to view young people. Measures are taken to address blind spots and ensure sightlines are not impeded, e.g. by using mirrors.	One		2		2	Overall, due to the structure of the unit, certain areas create blind spots that are difficult to rectify. As such, staff members are required to move in order to keep the children in sight. CCTV cameras assist with the observation.
		Two			3		
		Three		2			
		Four		2			
		Five			3		
		Six		2			
		Seven			3		

Table 4 Continued

Type 1 Standards for the Environment and Facilities (n = 25)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
1.4.4	Young people are cared for in the least restrictive environment possible, while ensuring appropriate levels of safety and promoting recovery.	One		2		3	Overall, as standard practice states, the TLC, as a therapeutic milieu environment, expects that all children admitted are cared for with no cruel or punitive influence. This may need to be reinforced to the more inexperienced staff members who may tend to utilise Time Outs more frequently when not required.
		Two			3		
		Three			3		
		Four			3		
		Five			3		
		Six		2			
		Seven			3		
1.6.1	A collective response to alarm calls and fire drills is agreed by the team and both are rehearsed 6 monthly.	One	1			1	Currently, despite the presence of a disaster plan and allocated health and safety representative, collective response to alarm calls and fire drills have been rarely carried at the TLC.
		Two		2			
		Three		2			
		Four	1				
		Five	1				
		Six		2			
		Seven			3		
1.6.1*	The Unit/unit has a mechanism for responding to low/unsafe staffing levels, when they fall below minimum agreed levels, including: A method for the team to report concerns about staffing levels; Access to additional staff members; An agreed contingency plan, such as the minor and temporary reduction of non-essential services.	One		2		3	Overall, the TLC does have a mechanism in place when reported to management for concerns surrounding staffing shortages. There is regular access to agency nursing staff externally when in need but these vacancies are not filled immediately due to their unfamiliarity with the location of the TLC and other infrastructural concerns.
		Two			3		
		Three			3		
		Four			3		
		Five			3		
		Six	1				
		Seven		2			

Table 4 Continued

Type 1 Standards for the Environment and Facilities (n = 25)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
1.6.2	Emergency medical resuscitation equipment (crash bag), as required by Trust/organisation guidelines, is available within 3 minutes and its location is clearly identified.	One			3	3	At present, the unit possesses an emergency trolled which is stationed within the clinic room for readily and easy access when needed. Nurses inspect the supplies regularly for any expired equipment that needs replacing.
		Two			3		
		Three			3		
		Four		2			
		Five			3		
		Six		2			
		Seven			3		
1.6.3	The crash bag is maintained and checked weekly, and after each use.	One		2		2	The general consensus is that the crash bag, as per standard practice, is checked regularly (i.e., twice daily) by nursing staff.
		Two		2			
		Three		2			
		Four		2			
		Five			3		
		Six			3		
		Seven			3		
1.6.4	There is an alarm system in place (e.g. panic buttons) and this is easily accessible.	One	1			2	An alarm system is in place that is accessible for staff members. No panic buttons are available. Instead whistles are present on the ward that can be used to notify security for assistance.
		Two		2			
		Three	1				
		Four		2			
		Five		2			
		Six	1				
		Seven		2			

Table 4 Continued

Type 1 Standards for the Environment and Facilities (n = 25)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
1.6.6	An audit of environmental risk is conducted annually and a risk management strategy is agreed. *Guidance: This includes an audit of ligature points.*	One	1			2	Overall, there appears to be some contention with the rate and extent of which environmental audits and risk management strategy are conducted. Some agree that such audits are not completed annually, where others have argued that more regular audits completed, such as twice a year to weekly.
		Two		2			
		Three	1				
		Four		2			
		Five		2			
		Six			3		
		Seven		2			

Note. The unit standards that are marked with an * are duplicate standards from the updated and revised standards post the 2016 reviews. These revisions are either based on the type status or simply new unit standards that have been added to the overall checklist with the same unit standard number.

As shown in Table 4, of the 25 Type 1 unit standards measured, a total of three (12%) possessed overall modes that indicated that they were not met. A total of 11 (44%) possessed overall modes that indicated that they were partially met and a total of 11 (44%) possessed overall modes that indicated that they were fully met.

In summary, the results indicate that less than half of the type 1 unit standards are fully met and align with the QNIC standards.

Type 2 Unit Standards: Category 1

Table 5 presents the environment and facilities standards that are identified as Type 2 (n=27).

Table 5

Type 2 Standards for the Environment and Facilities (n = 27)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
1.1.1	The Unit/unit entrance and key clinical areas are clearly signposted	One		2		2	Overall, the TLC does have signposting but it is not sufficient. The parking area and entrances to the units have been highlighted as areas requiring more signage. The signage is in different languages but rarely all three languages of English, Afrikaans and isiXhosa.
		Two		2			
		Three		2			
		Four		2			
		Five			3		
		Six		2			
		Seven		2			
1.1.3	The unit is in a good state of repair and maintenance is carried out in a timely manner	One	1			2	Overall, there is a general consensus that, structurally, the TLC unit is in a state of disrepair and poses numerous safety concerns to those occupying its spaces. Furthermore, maintenance services and repairs on the facilities tend to take significantly long to be carried out.
		Two	1				
		Three		2			
		Four		2			
		Five	1				
		Six		2			
		Seven		2			
1.1.4	Staff members and young people can control heating, ventilation and light or have access to support from facilities.	One	1			1	Overall, despite access to control of heating via wall and mobile heaters, the state of their functionality is questionable which poses a problem during winter periods. The lighting is adequate for most of the facility. However, the TLC currently has poor and inadequate ventilation with no air conditioning systems implemented largely as a result of its building construction.
		Two		2			
		Three			3		
		Four		2			
		Five	1				
		Six	1				
		Seven		2			

Table 5 Continued

Type 2 Standards for the Environment and Facilities (n = 27)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
1.1.5	Waiting rooms/areas are provided.	One		2		2	Currently, there are no designated waiting rooms/areas, so to speak, in the TLC. Instead a small foyer, present with available seating, is utilised for this purpose. There are only waiting rooms situated for the outpatient services in the two separate buildings.
		Two		2			
		Three			3		
		Four	1				
		Five		2			
		Six	1				
		Seven			3		
1.1.6	There is indoor space for recreation which can accommodate all young people.	One			3	2	Two core indoor spaces having been identified for recreational purposes. The areas are multipurpose as one serves as a bedroom and space where nurses may observe the children and the other caters for visiting from carers/parents, occasional table tennis and snacking.
		Two		2			
		Three			3		
		Four		2			
		Five	1				
		Six		2			
		Seven		2			
1.1.7	There is a designated outdoor space.	One			3	3	Overall, the TLC does house an adequately sized and safely accessible outdoor space for the children. Accordingly, a few activities may be engaged with by the children but more recreational activities are suggested to be needed.
		Two		2			
		Three			3		
		Four			3		
		Five		2			
		Six		2			
		Seven			3		

Table 5 Continued

Type 2 Standards for the Environment and Facilities (n = 27)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
1.1.9	The unit contains rooms for individual and group meetings.	One			3	3	Overall, numerous spaces have been identified for both individual (counseling and interviewing) and group/team meetings accordingly.
		Two			3		
		Three			3		
		Four			3		
		Five	1				
		Six		2			
		Seven			3		
1.1.10	The Unit/unit has a designated dining area, which is available during allocated mealtimes.	One			3	3	A dining room has been identified to serve its core purpose for the children during breakfast, snack, lunch and supper with all necessary utensils present. The furniture may need to be improved for comfort reasons.
		Two			3		
		Three			3		
		Four			3		
		Five			3		
		Six			3		
		Seven			3		
1.1.11	There is designated teaching space for education which can accommodate all young people in the unit.	One			3	3	As part of the schooling component of multidisciplinary service, a designated teaching space has been identified for the children. It includes a viewing room, teacher's office and library area.
		Two			3		
		Three			3		
		Four			3		
		Five			3		
		Six		2			
		Seven			3		

Table 5 Continued

Type 2 Standards for the Environment and Facilities (n = 27)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
1.1.12*	All units must have an appropriate policy which highlights how a service secludes. This should include the threshold at which a young person would be transferred to a more secure environment.	One	1			3	Overall, the TLC does not necessarily possess a seclusion policy but instead has a secured and appropriate Time Out policy which shares partial similarities with seclusion. There is no policy present for transferring any of the children admitted to another secure unit but guidelines can be followed should any patient become completely unmanageable.
		Two			3		
		Three			3		
		Four		2			
		Five			3		
		Six			3		
		Seven			3		
1.1.13	There is a designated area or room (de-escalation space) that the team may consider using, with the young person's agreement, specifically for the purpose of reducing arousal and/or agitation.	One	1			3	Within the TLC, there are two identified Time Out rooms which are argued to help as de-escalation spaces for children who require a space to manage and contain their behaviour and emotions. There is no sole de-escalation room situated.
		Two			3		
		Three			3		
		Four			3		
		Five			3		
		Six			3		
		Seven		2			
1.1.14	All young people can access a range of current age appropriate resources for entertainment, which reflect the Unit/unit's population.	One		2		2	The general consensus is that there does appear to be a resource space for the children with available activities and play material. However, they are not argued to be age-appropriate, especially for children with age gaps of six to seven years. Furthermore, due to a lack of funding and the destruction of the resources by the children admitted during periods of aggression and frustration, it takes a while to get the resources replaced accordingly.
		Two		2			
		Three		2			
		Four		2			
		Five	1				
		Six	1				
		Seven		2			

Table 5 Continued

Type 2 Standards for the Environment and Facilities (n = 27)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
1.1.15	One computer is provided for every two young people in school	One	1			2	Overall, the school possesses a total of five computers, of which the children have access to three for educational purposes. Therefore, the ratio of 2:1 is usually jeopardized when six patients are present in school.
		Two		2			
		Three		2			
		Four			3		
		Five			3		
		Six		2			
		Seven			3		
1.1.18	There are sufficient IT resources (e.g. computer terminals) to provide all practitioners with easy access to key information, e.g. information about services/conditions/ treatment, young people records, clinical outcome and service performance measurements.	One	1			2	Overall, the TLC appears to house fair access to computer terminals and internet access by UCT and Provincial Government Terminals but not all staff have access to them nor are they readily upgraded. Records are mainly kept on paper instead of electronically.
		Two		2			
		Three			3		
		Four		2			
		Five			3		
		Six		2			
		Seven			3		
1.1.19	There are facilities for young people to make their own hot and cold drinks and snacks where risk permits.	One			3	3	A fully functioning kitchen is available for these services but due to the children's age, they are normally accompanied by housekeeping and nursing when requesting to make drinks and snacks.
		Two			3		
		Three			3		
		Four		2			
		Five			3		
		Six		2			
		Seven			3		

Table 5 Continued

Type 2 Standards for the Environment and Facilities (n = 27)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
1.1.20	Parents/carers have access to refreshments at the unit	One	1			1	Overall, parents and carers are not catered for in terms of accessing refreshments. Only staff members have this accessibility.
		Two		2			
		Three	1				
		Four		2			
		Five	1				
		Six	1				
		Seven		2			
1.1.21	Units can provide information for families about local accommodation.	One	1			1	Overall, the TLC does not have accommodation for family members of the children admitted. This service is provided by the main Red Cross War Memorial Children's Hospital (RCWMCH). Accommodation information is not routinely recommended.
		Two	1				
		Three		2			
		Four	1				
		Five			3		
		Six		2			
		Seven			3		
1.1.22	Unit/unit-based staff members have access to a dedicated staff room.	One			3	3	The TLC does have an accessible staff/tea room for staff members. However, not all members utilise it during breaks.
		Two			3		
		Three			3		
		Four			3		
		Five			3		
		Six			3		
		Seven			3		

Table 5 Continued

Type 2 Standards for the Environment and Facilities (n = 27)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
1.3.3	All young people have single bedrooms according to need.	One	1			1	Overall, due to structural space within the ward, only two bedrooms that accommodate more than one child in each are available. As such, single bedroom options are not available. Some children, based on clinical need, may need to be provided with one bedroom space within the multi-bed rooms.
		Two	1				
		Three	1				
		Four	1				
		Five	1				
		Six	1				
		Seven	1				
1.3.5	The unit has at least one bathroom/shower room per 3 young people.	One		2		3	Overall, the unit possesses one shower and one bathroom with three toilets (one for staff, one for girls and one for boys). With a six patient capacity, this requirement appears to be satisfied.
		Two			3		
		Three		2			
		Four			3		
		Five	1				
		Six			3		
		Seven			3		
1.3.7	There are areas that may become single-sex lounges as required.	One	1			1	Overall, neither spacing nor relevance to the TLC itself permits any potential for single-sex lounges to be developed. This would not fully include play areas mentioned previously.
		Two	1				
		Three	1				
		Four	1				
		Five	1				
		Six	1				
		Seven	1				

Table 5 Continued

Type 2 Standards for the Environment and Facilities (n = 27)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
1.3.9	The unit has at least one quiet room other than young people's bedrooms.	One		2		2	Overall, the TLC does not possess a designated quiet room so to speak. Multipurpose spaces offer this service where children can meet and engage with visitors. However, these spaces usually have people who walk through them.
		Two		2			
		Three		2			
		Four		2			
		Five		2			
		Six					
		Seven		2			
1.3.10	There is a designated space for young people to receive visits from children, with appropriate facilities such as toys, books.	One		2		2	Overall, the TLC does not possess a designated visiting space but multipurpose spaces within the unit offer these services for the children and visitors/carers/parents as mentioned.
		Two		2			
		Three		2			
		Four		2			
		Five	1				
		Six	1				
		Seven		2			
1.3.13	There is a safe place for young people to keep their property.	One		2		3	On the ward there are secure spaces, which include bedside cupboards and wardrobes, for the children to store away their belongings. They are, however, not all lockable and parents/carers are encouraged to take valuable property for safe-keeping.
		Two			3		
		Three			3		
		Four			3		
		Five			3		
		Six	1				
		Seven		2			

Table 5 Continued

Type 2 Standards for the Environment and Facilities (n = 27)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
1.3.14	There is a safe place for staff to keep their property.	One			3	3	Overall, lockers are identified but not all staff members have access to nor access them in general. They are particularly used by nursing staff.
		Two			3		
		Three			3		
		Four			3		
		Five	1				
		Six		2			
		Seven			3		
1.5.2	Young people are able to personalise their bedrooms	One		2		3	Overall, children are permitted to personalise their bedroom space with material of sentimental value to them, which is encouraged to the parents/carers, maintaining the appropriateness of them. This space is one that child needs to respect.
		Two			3		
		Three		2			
		Four			3		
		Five			3		
		Six	1				
		Seven			3		
1.6.5	Alarm systems/call buttons/personal alarms are available to young people and visitors, and instructions are given for their use.	One	1			1	Currently, no personal alarms/call buttons/alarm systems are made available to the children and the visitors. Largely due to the fact of their age and constant supervision and observation voiding the necessity for such resources.
		Two	1				
		Three	1				
		Four	1				
		Five	1				
		Six	1				
		Seven	1				

Note. The unit standards that are marked with an * are duplicate standards from the updated and revised standards post the 2016 reviews. These revisions are either based on the type status or simply new unit standards that have been added to the overall checklist with the same unit standard number.

Of the 27 Type 2 unit standards measured, six (22%) possessed overall modes that indicated that they were not met. Nine (33%) possessed overall modes that indicated that they were partially met and a total of 12 (45%) possessed overall modes that indicated that they were fully met. As such, for the Type 2 unit standards, the majority of standards were found to be fully met by the respective participants despite how narrow the gaps were between those rendered as partially met and fully met.

Type 3 Unit Standards: Category 1

Table 6 presents the Type 3 standards of the environment and facilities category (n=3).

Table 6

Type 3 Standards for the Environment and Facilities (n = 3)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
1.3.6	Every young person has an en-suite bathroom.	One	1			1	There is only one bathroom indicated to be available and it is not en-suite nor would there be spacing or resources for such development.
		Two	1				
		Three	1				
		Four	1				
		Five	1				
		Six	1				
		Seven	1				
1.3.12	All young people can access a plug socket for electronic devices such as mobile phones where risk permits.	One	1			1	Overall, TLC policy does not permit any of the children admitted to have access to mobile phones or any devices are similar stature.
		Two	1				
		Three		2			
		Four	1				
		Five	1				
		Six	1				
		Seven	1				
1.5.1	Young people are consulted about changes to the Unit/unit environment.	One	1			3	The general consensus is that, not only are the children informed about changes to be made to the unit and ward, but there opinions are taken into consideration to a certain extent.
		Two			3		
		Three			3		
		Four			3		
		Five			3		
		Six		2			
		Seven		2			

As evidenced in Table 6, two out of the three unit standards possessed overall modes that indicated that they were not met, whilst one of the unit standards possessed an overall mode that indicated that it was fully met.

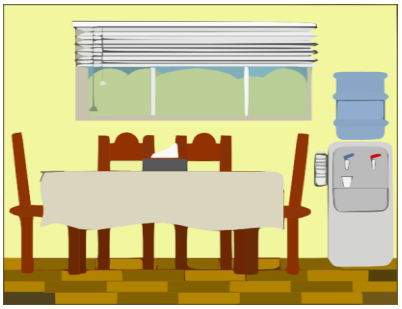
Based on the responses and critique of the unit standards for environment and facility, the evaluator identified which standards were deemed to be the highest met unit standards.

Highest Met Unit Standards of Category 1

The section below illustrates the highest met unit standards across Category 1. The highest met standards were determined by the extent to which the standard was collectively rendered fully met by the participants (i.e., the standards which all participants rendered as fully met).

1.1.8 (Type 1):

Young people are able to access safe outdoor space every day where clinically appropriate.



1.1.10 (Type 2):

The unit has a designated dining area, which is available during allocated mealtimes.

1.1.22 (Type 2):

Unit/unit-based staff members have access to a dedicated staff room.

1.4.1 (Type 1):

The team keeps medications in a secure place, in line with the organisation's medicine management policy.

Figure 3. Highest Met Unit Standards of Category 1.

Category 2: Staffing and Training

The Staffing and Training Category focuses on the effectiveness of the multidisciplinary team established at the TLC and levels of support, training and development each of the members have access to and utilise. There are a total of 65 unit standards for this category.

Type 1 Unit Standards: Category 2

Table 7 presents the standards of Category 2 (i.e., staffing and training at the TLC) that are identified as Type 1 (n=36). The individual responses of the participants can be seen in Appendix D.

Table 7

Type 1 Standards for the Staff and Training (n = 36)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
2.1.1	Where there are high dependency/high acuity cases (e.g. high levels of observation, use of seclusion, increased risk of violence or self-harm), there is a minimum ward staff to young person ratio of 1:1 to 3:1 for the most highly disturbed cases.	One		2		2	Overall, based on evidence of nursing day-duty and night-duty rosters, to some degree a 1:1 staff to child ratio at the TLC is met as its maximum, but not effectively. The case for this is that there are current nursing shortages and inexperienced nursing agency staff to manage high risk patients. A 3:1 ratio has reportedly never been support at the TLC.
		Two		2			
		Three		2			
		Four		2			
		Five			3		
		Six		2			
		Seven		2			
2.1.2	Where there are medium dependency (e.g. 10-minute checks, intensive support at meal times), there is a minimum ward staff to young person ratio of 1:2.	One		2		2	Overall, the TLC aim to provide for the children admitted where duty rosters would confirm this. There is always someone present for medium to high risk children, especially when they are suicidal and aggressive. Usually, four nurses per shift even if the children count is six. However, it is difficult when staff members are inexperienced.
		Two		2			
		Three			3		
		Four		2			
		Five			3		
		Six	1				
		Seven			3		

Table 7 Continued

Type 1 Standards for the Staff and Training (n = 36)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
2.1.3	Where young people are on general observations there is a ward staff to young person ratio of 1:3.	One		2		3	In general, this ratio of 1:3 for general observations is upheld at the TLC. There are 6 staff members per shift daily with a minimum or average of 1:3 staff to child ratio for day- and night-duty.
		Two			3		
		Three			3		
		Four			3		
		Five			3		
		Six		2			
		Seven			3		
2.1.4	At night-time in a 6 bedded unit with general observations there is a minimum of two staff on duty, including one registered member of staff and access to additional support as appropriate.	One			3	3	Overall, the minimum number of nursing staff on duty supervising and observing the children admitted at the TLC is two and never less. The duty roster will outline who is on duty. At night, one professional nurse and nursing assistant is usually present. There is concern, however, surrounding the experience, level of training and request for additional staff.
		Two			3		
		Three			3		
		Four			3		
		Five			3		
		Six		2			
		Seven			3		
2.1.5	Senior nursing staff has the authority to arrange for additional staff to cover shifts in an emergency.	One		2		3	Overall, nursing management at the TLC possesses the authority to request, not arrange, extra staff in the case of shortages. This request is usually not always met due financial constraints or lack of appropriate and experienced agency staff.
		Two		2			
		Three			3		
		Four			3		
		Five			3		
		Six		2			
		Seven			3		

Table 7 Continued

Type 1 Standards for the Staff and Training (n = 36)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
2.1.7	Where bank and agency staff is used, they are familiar with the unit. *Guidance: a maximum of 15% of staff during a week are unfamiliar (non-permanent or non-regular) bank or agency staff.*	One		2		2	Overall, the TLC and nursing management try to consistently arrange for agency staff members who have worked previously at the TLC and are familiar with the unit. As reported, this level of familiarity is not always the case. As such, a orientating policy and procedure should be implemented prior to agency staff filling in.
		Two		2			
		Three		2			
		Four		2			
		Five		2			
		Six		2			
		Seven		2			
2.2.1	A typical unit with 6 beds includes a minimum of two registered nurses that have relevant child and young people experience, per day shift and one at night. At least one of which should have completed preceptorship.	One		2		2	Overall, current nursing staff employed within the TLC have differing experience in child psychiatry. However, the majority of staff have limited experience, given that more experienced staff have retired; shortages in staff and inconsistent access to mentorships and courses.
		Two		2			
		Three			3		
		Four			3		
		Five		2			
		Six	1				
		Seven		2			
2.2.2	A typical unit with 6 beds includes 1 WTE ward manager (band 7+ or equivalent).	One		2		2	Currently, the TLC has 0.5 WTE ward manager/operational manager appointed as 50% of responsibilities covers Outpatient services and the other 50% covers the Inpatient services at the TLC unit.
		Two		2			
		Three			3		
		Four		2			
		Five		2			
		Six		2			
		Seven		2			

Table 7 Continued

Type 1 Standards for the Staff and Training (n = 36)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
2.3.1	A typical unit with 6 beds includes at least 1 WTE consultant child and adolescent psychiatrist input (which may be provided by two clinicians in a split post).	One	1			2	Currently, the TLC unit has 0.5 WTE Child and Adolescent Consultant (i.e., not full time) as the post also covers 50% of community liaison with the main hospital RCWMCH.
		Two		2			
		Three			3		
		Four			3		
		Five			3		
		Six		2			
		Seven		2			
2.3.3	A typical unit with 6 beds includes at least 1 WTE clinical psychologist.	One	1			2	Currently, the TLC has 0.5 WTE Clinical Psychologist (i.e., not full time) as the post covers 50% of Outpatient services with the Division of Child and Adolescent Psychiatry (DCAP).
		Two		2			
		Three			3		
		Four			3		
		Five			3		
		Six		2			
		Seven		2			
2.3.15	Unit staff have input from a pharmacist.	One		2		2	Overall, the TLC does have access to a pharmacist via telephone or email. He or she is, however, based at the main hospital RCWMCH, therefore being geographically separated from the TLC unit. Nursing staff collects and drops off prescribed medication from the pharmacist.
		Two		2			
		Three		2			
		Four		2			
		Five			3		
		Six	1				
		Seven			3		

Table 7 Continued

Type 1 Standards for the Staff and Training (n = 36)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
2.3.16	There is an identified duty doctor available at all times to attend the ward/unit, including out of hours. The doctor can: • Attend the ward/unit within 30 minutes in the event of a psychiatric emergency; • Attend the ward/unit within 1 hour during normal working hours; • Attend the ward/unit within 4 hours when out of hours.	One			3	3	Overall, the TLC has access to an onsite doctor who is available to comply with the times specified. In some cases, it may be difficult for them to attend the TLC within 30 minutes as they may be at a clinic or consulting.
		Two			3		
		Three			3		
		Four			3		
		Five			3		
		Six		2			
		Seven			3		
2.3.17	There has been a review of the staff capacity and skill mix of the team within the past 12 months. This is to identify any gaps in the team and to develop a balanced workforce which meets the needs of the ward/unit.	One	1			1	Currently, a review of staff levels is being undertaken. This review, however, reportedly does not take the shape of a formal skills matrix given that staff members have had high turn-over as of late making it difficult to get an accurate reflection of staff skill levels.
		Two		2			
		Three	1				
		Four	1				
		Five			3		
		Six	1				
		Seven		2			
2.3.17*	Young people returning from ward leave are able to access a bed on their ward within 6 hours.	One			3	3	Overall, children admitted to the TLC who returns from the weekend or from school holiday leave always has a bed kept for their use upon their return.
		Two			3		
		Three			3		
		Four		2			
		Five			3		
		Six			3		
		Seven			3		

Table 7 Continued

Type 1 Standards for the Staff and Training (n = 36)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
2.3.17*	Staff members who administer medications have been assessed as competent to do so. Assessment is done using a competency-based tool.	One	1			3	Overall, nursing staff employed at the TLC are trained at a credible tertiary institution. These are professionals who are assessed according to their training to administer medication.
		Two			3		
		Three		2			
		Four	1				
		Five			3		
		Six			3		
		Seven			3		
2.4.1	There are written documents that specify professional, organisational and line management responsibilities.	One		2		2	Overall, this information would be made available through DCAP Organogram and Job descriptions. Majority of responses report that staff members are aware of responsibilities and professionalism, but lack confidence within child psychiatry and the uncertainty surrounding the availability of such documentation.
		Two		2			
		Three		2			
		Four		2			
		Five			3		
		Six		2			
		Seven			3		
2.4.3	In a typical 6 bedded unit, there is time scheduled in staff rotas to allow 30 minute handover sessions between shifts.	One		2		3	Overall, during morning and evening routines for staff, handovers do take place usually lasting more than 30 minutes within a handover room.
		Two			3		
		Three			3		
		Four		2			
		Five			3		
		Six			3		
		Seven			3		

Table 7 Continued

Type 1 Standards for the Staff and Training (n = 36)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
2.4.4	The team has integrated records of the young people which can be accessed by all clinical staff.	One	1			3	Overall, the clinical records/folders on the children admitted are available for access from multidisciplinary team members but they are not integrated with the nursing notes which are kept separate at the nursing station.
		Two			3		
		Three			3		
		Four		2			
		Five		2			
		Six		2			
		Seven			3		
2.4.5	The unit has a whistleblowing policy and staff members are able to raise concerns without prejudicing their position.	One	1			1	Overall, the responses outlined some contention as to the knowledge of present whistleblowing policies in place. As stated, there are incidences concerns that staff are aware of in which relevant matters can be brought up. This can similarly be done during supervision. As such, there is no specific policy to the TLC context.
		Two	1				
		Three		2			
		Four	1				
		Five			3		
		Six	1				
		Seven			3		
2.4.6	The ward/unit actively supports staff health and well-being. *Guidance: For example, providing access to support services, monitoring staff sickness and burnout, assessing and improving morale, monitoring turnover, reviewing feedback from exit reports and taking action where needed.*	One		2		2	Overall, staff members have access to ICAS for support. Furthermore, there is staff wellness, team-building and off-site support available but it is unclear whether staff members are aware of these avenues or have the time to access them. Feedback on staff morale and well-being are shared inconsistently.
		Two		2			
		Three		2			
		Four		2			
		Five		2			
		Six		2			
		Seven		2			

Table 7 Continued

Type 1 Standards for the Staff and Training (n = 36)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
2.4.8	Staff members are able to take breaks during their shift that comply with the European Working Time Directive (or local equivalent). *NB: With the European Working Time Directive you can't work more than 48 hours a week on average - normally averaged over 17 weeks. This law is sometimes called the 'working time directive' or 'working time regulations'.*	One				3	Overall, according to basic conditions of employment regulations, staff members, specifically nursing, work a 40 or more hour week whereby additional time is utilised during their lunch and tea breaks leaving less room for recuperation.
		Two			3		
		Three			3		
		Four			3		
		Five			3		
		Six		2			
		Seven			3		
2.6.1	The team receives training, consistent with their roles, on risk assessment and risk management. This is refreshed in accordance with local guidelines. This includes, but is not limited to, training on: • Safeguarding vulnerable adults and children; • Assessing and managing suicide risk and self-harm; • Prevention and management of aggression and violence.	One		2		2	Overall, there is regular training implemented staff members at the TLC, such as Timian 3-day course and weekly practice sessions. It is unclear, however, where all topics are available to be covered, whether all staff attend and whether all staff have been trained in risk management which is important.
		Two		2			
		Three		2			
		Four		2			
		Five			3		
		Six		2			
		Seven			3		
2.6.2	Care co-ordination including transfer of care.	One				3	Overall, a caring approach appears to be utilised within the TLC as covered through multiple departments and multidisciplinary meetings. However, not all care coordination is conducted appropriately in certain departments.
		Two		2			
		Three			3		
		Four		2			
		Five			3		
		Six					
		Seven			3		

Table 7 Continued

Type 1 Standards for the Staff and Training (n = 36)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
2.6.3	Managing relationships and boundaries between young people and staff, including appropriate touch.	One	1			3	Overall, behavioural management policy and training (e.g., Timian) provides adequate training and support to staff to understand clear and appropriate boundaries of space and touch which are regularly addressed in team meetings and handovers.
		Two		2			
		Three			3		
		Four		2			
		Five			3		
		Six		2			
		Seven			3		
2.6.4	Observation and engagement.	One				3	Overall, based on the TLC therapeutic programme, individual psychotherapy and nursing care plans, observing the children's mood and behaviour and their engagement with others is a crucial component to the unit.
		Two					
		Three			3		
		Four		2			
		Five			3		
		Six		2			
		Seven			3		
2.6.5	The use of legal frameworks, such as the Mental Health Act (or equivalent) and the Mental Capacity Act (or equivalent).	One			3	3	Specifically, the Mental Health Care Act No 17 of 2002 and The Child Care Act No 38 of 2005 govern the work of the TLC and guides the practitioner relevant to programme established at the TLC.
		Two			3		
		Three			3		
		Four			3		
		Five			3		
		Six			3		
		Seven			3		

Table 7 Continued

Type 1 Standards for the Staff and Training (n = 36)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
2.6.6	All qualified nursing and medical staff that administer rapid tranquillisation need to have done Intermediate Life Support training.	One		2		2	Overall, not all staff of the TLC have had or attended life support training. It is available, however, where selected staff members are sent for training accordingly. Rapid sedation is not routinely utilised at the TLC, except when absolutely needed.
		Two		2			
		Three			3		
		Four		2			
		Five			3		
		Six		2			
		Seven			3		
2.6.7	All other staff have done Basic Life Support training.	One		2		2	Overall, it is predominantly nursing and medical staff who have accessed and/or completed Basic Life Support Training. Not all other staff have completed it.
		Two	1				
		Three		2			
		Four	1				
		Five			3		
		Six	1				
		Seven		2			
2.7.2	Staff members receive an induction programme specific to the ward/unit that covers: • The purpose of the ward/unit; • The team's clinical approach; • The roles and responsibilities of staff members; • The importance of family and carers; • Care pathways with other services. *Guidance: This induction should be over and above the mandatory Trust or organisation-wide induction programme*	One		2		2	Overall, there are policies in place which include RCWMCH induction course for permanent staff, TLC orientation, monitoring of implementation of orientation process according to needs of professional departments. Essential induction to the unit is discipline specific where not all aspects listed are reportedly covered such as point three.
		Two		2			
		Three			3		
		Four		2			
		Five			3		
		Six			3		
		Seven		2			

Table 7 Continued

Type 1 Standards for the Staff and Training (n = 36)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
2.7.3	Bank and agency staff receives an induction based on an agreed list of core competencies. *Guidance: This should include arrangements for shadowing colleagues on the team; jointly working with a more experienced colleague; being observed and receiving enhanced supervision until core competencies have been assessed as met.*	One	1			2	Overall, orientation of bank and agency staff to the unit is limited. It is completed on the day of the shift leaving little time to orientate and assess relevant competencies which is reportedly never done. It makes it difficult given that these staff members are only brought in during staff shortages.
		Two		2			
		Three			3		
		Four		2			
		Five		2			
		Six		2			
		Seven		2			
2.8.1	All clinical staff members receive individual clinical supervision at least monthly, or as otherwise specified by their professional body.	One		2		3	Overall, majority, if not all, TLC clinical staff receive clinical supervision applicable to their position (e.g., nursing will receive supervision from the clinical psychologist). However, the junior staff require more supervision.
		Two			3		
		Three			3		
		Four			3		
		Five			3		
		Six			3		
		Seven			3		
2.8.4	Staff members, young people and carers who are affected by a serious incident are offered a debrief within 24 hours and post incident support.	One		2		2	Overall, there are many pathways which provide pathways to staff support post incident experienced, such as ICAS Employees Wellness Programme. Children admitted who are affected receive physical and emotional support from staff but the debriefing does not always occur within 24 hours of the incident.
		Two		2			
		Three			3		
		Four		2			
		Five			3		
		Six		2			
		Seven			3		

Table 7 Continued

Type 1 Standards for the Staff and Training (n = 36)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
2.8.7	All newly qualified staff members are allocated a preceptor to oversee their transition onto the ward/unit.	One		2		3	Overall, newly appointed nursing staff are assigned a mentor whilst clinical staff are allocated supervision according to professional field at the TLC. Furthermore, most staff management who support them. Mentors are not always available however.
		Two		2			
		Three			3		
		Four		2			
		Five			3		
		Six			3		
		Seven			3		
2.8.8	All staff members receive an annual appraisal and personal development planning (or equivalent).	One			3	3	Overall, annual performance and development plans and quarterly appraisal plans are carried out through the Staff Performance Management System (SPMS) at the TLC. It forms part of the job requirement.
		Two			3		
		Three		2			
		Four			3		
		Five			3		
		Six			3		
		Seven			3		
2.9.2	Human resources staff ensures that all unit staff, including temporary staff, undergoes a Disclosure and Barring Service (DBS) check (or local equivalent) and are checked against the Protection of Children Act (POCA) register before appointment. Ongoing monitoring of this is carried out every three years.	One		2		2	Overall, the Human Resources Department conducts police clearance checks for all staff members who are part of the Department of Health. It is unclear whether this process is carried out every three years.
		Two			3		
		Three			3		
		Four		2			
		Five		2			
		Six		2			
		Seven			3		

Table 7 Continued
Type 1 Standards for the Staff and Training (n = 36)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
2.9.3	Human resources staff ensure that all staff with a professional regulatory body are checked for appropriate registration on recruitment and again at renewal date.	One		2		3	Overall, proof of professional regulatory body registration is reportedly required as part of the recruitment and placement process. This applies to all Department of Health Staff. For example, nurses cannot practice without it or the renewal of registration.
		Two			3		
		Three			3		
		Four		2			
		Five		2			
		Six			3		
		Seven			3		

Note. The unit standards that are marked with an * are duplicate standards from the updated and revised standards post the 2016 reviews. These revisions are either based on the type status or simply new unit standards that have been added to the overall checklist with the same unit standard number.

Of the 36 Type 1 unit standards measured, two (5.56%) possessed overall modes that indicated that they were not met. A total of 19 (52.78%) possessed overall modes that indicated that they were partially met and a total of 15 (41.66%) possessed overall modes that indicated that they were fully met. As such, for the Type 1 unit standards, the majority of standards were found to be partially met by the respective participants despite how narrow the gaps were between those rendered as partially met and fully met. The least number of unit standards were recorded as not met.

Type 2 Unit Standards: Category 2

Table 8 presents the Type 2 standards of the staffing and training category (n=24).

Table 8

Type 2 Standards for the Staff and Training (n = 24)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
2.1.6	The unit is staffed by permanent staff, and bank and agency staff are used only in exceptional circumstances e.g. in response to additional clinical need. *Guidance: A CAMHS inpatient unit is likely to have a problem with over-use of staff if more than 15% of staff are bank or agency staff during a week or if more than one member of staff on a shift are bank or agency. Bank and agency staff should not be used for more than two shifts in a day.*	One	1			3	Currently, all multidisciplinary clinical staff members are permanent staff where vacancies are present in nursing department. As such, agency staff make up more than 15% (e.g., 25%) was they also issued in for serious cases such as for suicide watch.
		Two		2			
		Three			3		
		Four		2			
		Five			3		
		Six	1				
		Seven			3		
2.1.8	Where bank and agency staff are used, they are familiar with the service and experienced in working with young people with mental health problems.	One		2		2	Overall, the TLC tries their best to organise consistent agency staff who are more experienced and have worked at the TLC unit previously through nursing management. This proves to be a difficult process to achieve as staff members require constant supervision and availability.
		Two		2			
		Three			3		
		Four		2			
		Five		2			
		Six		2			
		Seven		2			

Table 8 Continued

Type 2 Standards for the Staff and Training (n = 24)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
2.3.2	A unit with 6 beds includes at least 1 WTE nonconsultant Child and Adolescent Psychiatrist input.	One	1			2	As of late, the TLC unit has had 0.5 WTE nonconsultant Child and Adolescent Psychiatrist input within a 6 month contract. This position is usually taken up by a senior registrar. It is not a full time post.
		Two		2			
		Three		2			
		Four		2			
		Five			3		
		Six		2			
		Seven		2			
2.3.4	A typical unit with 6 beds includes at least 0.5 WTE Social Worker.	One		2		3	Currently, 0.5 WTE Social Worker is appointed. He/she covers 50% each respectively of their duties with TLC and Outpatient services.
		Two			3		
		Three			3		
		Four			3		
		Five			3		
		Six		2			
		Seven			3		
2.3.5	A typical unit with 6 places includes at least 0.5 WTE occupational therapist.	One	1			2	Currently, the appointed Occupational Therapist at the TLC offers input two days a week (Monday and Wednesday) which is just short of 0.5 WTE.
		Two		2			
		Three			3		
		Four		2			
		Five			2		
		Six		2			
		Seven		2			

Table 8 Continued

Type 2 Standards for the Staff and Training (n = 24)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
2.3.6	The unit has formal arrangements to ensure easy access to therapists trained in psychological interventions (e.g. CBT, child and adolescent psychotherapy, psychodynamic psychotherapy, MBT, DBT, IPT, EMDR) List is not exhaustive.	One		2		2	Overall, arrangements to provide access, when clinically indicated, can be made but it is however limited. Such interventions may be provided by the Clinical Psychologist, external clinicians and/or Outpatient services where applicable.
		Two		2			
		Three			3		
		Four		2			
		Five		2			
		Six	1				
		Seven		2			
2.3.7	The unit has formal arrangements to ensure easy access to a dietician.	One		2		3	Overall, arrangements can be made for contact and consultation with the Dietician Department at the main hospital RCWMCH who is generally always available when needed for the children admitted at the TLC.
		Two			3		
		Three			3		
		Four			3		
		Five			3		
		Six		2			
		Seven			3		
2.3.8	The unit has formal arrangements to ensure easy access to a speech and language therapist.	One		2		2	Overall, there are referral pathways for speech and language therapists through the main hospital RCWMCH but the children are generally seen based on their age and position within school. Access is not always easy.
		Two		2			
		Three		2			
		Four	1				
		Five			3		
		Six	1				
		Seven		2			

Table 8 Continued

Type 2 Standards for the Staff and Training (n = 24)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
2.3.10	A typical unit with 6 beds includes at least 0.5 WTE family therapist.	One	1			1	There is no designated family therapist at the TLC as part of staff and multidisciplinary team. Some of the role of this position is, however, covered by the psychologists and social worker as part family therapeutic work in the programme.
		Two	1				
		Three		2			
		Four		2			
		Five		2			
		Six	1				
		Seven	1				
2.3.11	There is a minimum of one qualified teacher to four students per lesson. Requires a teacher to pupil ratio of 1:4 or less, the presence of specialist nursing staff or the provision of a room for individual teaching.	One		2		3	Overall, the TLC schooling component as one registered primary school teacher per 6 children in the ward and classroom. He/she is supported by a minimum of two nursing staff and one classroom assistant during class hours.
		Two		2			
		Three			3		
		Four			3		
		Five		2			
		Six	1				
		Seven			3		
2.3.14	A typical unit with 6 beds includes 1 WTE administrator (band 3 or above or local equivalent).	One	1			2	Overall, the ward has clerical input four mornings a week which is ultimately less than 1 WTE. He/she shares the administrative responsibilities with the Outpatient services. .
		Two		2			
		Three		2			
		Four		2			
		Five			1		
		Six		2			
		Seven		2			

Table 8 Continued

Type 2 Standards for the Staff and Training (n = 24)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
2.3.17	Staff members can access leadership and management training appropriate to their role and specialty.	One		2		3	Overall, training is available and can be accessed by staff after special leave via the skills development department at the main hospital RCWMCH has been approved. It forms part of individual staff development plans based on role and specialty. It is, however, difficult to access due to operational requirements.
		Two			3		
		Three		2			
		Four			3		
		Five			3		
		Six		2			
		Seven			3		
2.3.17*	The team has received training in reflective practice.	One	1			2	Overall, there has not been specific training in reflective practice that has been available for all staff members other than those from the psychiatry and psychologist department. Some aspects of reflective practice have been touched on in other training schedules.
		Two		2			
		Three			3		
		Four	1				
		Five			3		
		Six		2			
		Seven		2			
2.4.2	The MDT attends business meetings that are held at least monthly.	One			3	3	Overall, a number of meetings discussing various unit – in this case business related – aspects of the TLC are held weekly. Most relevant would be administrative meetings usually every Wednesday with respective multidisciplinary team members to discuss day-to-day operations for example.
		Two			3		
		Three			3		
		Four			3		
		Five			3		
		Six		2			
		Seven			3		

Table 8 Continued

Type 2 Standards for the Staff and Training (n = 24)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
2.4.7	The team has protected time for team-building and discussing service development at least once a year.	One			3	3	Overall, team-building activities at the TLC are scheduled and expected to be conducted monthly along with service development at least twice in one year. Attendance of them respectively is questionable.
		Two			3		
		Three			3		
		Four			3		
		Five			3		
		Six		2			
		Seven			3		
2.5.1	All qualified staff receives at least 5 days training and continuing professional development activities per year in line with their professional body, in addition to mandatory training.	One		2		3	Overall, all staff members have development plans but not necessarily all have access to training opportunities such as in-service training. There is good support, such as the assignment of mentors for a certain period for new nursing staff. Academic programmes are available on Fridays but not all staff attend the sessions.
		Two			3		
		Three		2			
		Four		2			
		Five			3		
		Six			3		
		Seven			3		
2.5.2	The organisation has a budget for staff training and development.	One			3	3	Currently, a set budget is allocated for training for government employees with access to funds of a maximum R10000 per annum according to RCWMCH policy.
		Two			3		
		Three		2			
		Four		2			
		Five					
		Six			3		
		Seven			3		

Table 8 Continued

Type 2 Standards for the Staff and Training (n = 24)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
2.6.8	Shared in-house multi-disciplinary team training, education and practice development activities occur on the ward/unit at least every 3 months. *Guidance: This includes discussion of evidence based treatment, for example, NICE guidelines.*	One	1			1	Overall, only Timian training for behavioural management is conducted regularly. No updates of NICE guidelines. There are regular in-house academic meetings but not all staff members attend these consistently.
		Two		2			
		Three			3		
		Four	1				
		Five		2			
		Six	1				
		Seven		2			
2.7.4	Young people, carers and staff members are involved in devising and delivering training face-to-face.	One	1			1	Generally, staff members have the primary figures involved in devising and implementing training, not children admitted or their respective parents/carers. This is primarily due to the age of appropriateness.
		Two		2			
		Three		2			
		Four		2			
		Five	1				
		Six	1				
		Seven	1				
2.8.2	All staff members receive monthly line management supervision, proportionate to their roles.	One		2		3	Overall, nursing staff line management meetings are held according to protocol which is implemented especially for newly registered nurses as a means of empowering them. Clinical staff engages with line managers monthly.
		Two			3		
		Three			3		
		Four		2			
		Five		2			
		Six			3		
		Seven			3		

Table 8 Continued

Type 2 Standards for the Staff and Training (n = 24)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
2.8.3	All supervisors have received specific training to provide supervision. This training is refreshed in line with local guidance.	One	1			1	Overall, the consensus is that only some supervisors have received training as part of their own professional training whilst the majority are supported but not provided with specific training at the TLC.
		Two		2			
		Three		2			
		Four	1				
		Five	1				
		Six	1				
		Seven		2			
2.8.5	Staff members have access to reflective practice groups.	One	1			2	Overall, there is uncertainty as to the specifics of this process and whether it is offered. In terms of support, feeling groups are held weekly which are facilitated by staff member. Furthermore, staff members do have external and internal support structures in place, such as ICAS.
		Two		2			
		Three			3		
		Four	1				
		Five			3		
		Six		2			
		Seven		2			
2.8.6	Staff members in training and newly qualified staff members are offered weekly supervision.	One	1			2	Overall, weekly supervision is not maintained due to off-duty scheduling issues, non-attendance and shift changes. Instead, supervision is held every alternative week or every second week. This remains a challenge.
		Two		2			
		Three			3		
		Four	1				
		Five			3		
		Six		2			
		Seven		2			

Table 8 Continued

Type 2 Standards for the Staff and Training (n = 24)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
2.9.1	Young people are involved in and influence the recruitment of unit staff.	One	1			1	Overall, there is no formal way or process of allowing for children under the age of 13 who are admitted to influence staff recruitment. Feedback on their experiences with staffing support has been attempted.
		Two		2			
		Three	1				
		Four	1				
		Five	1				
		Six	1				
		Seven		2			

Note. The unit standards that are marked with an * are duplicate standards from the updated and revised standards post the 2016 reviews. These revisions are either based on the type status or simply new unit standards that have been added to the overall checklist with the same unit standard number.

Of the 24 Type 2 unit standards measured, a total of five (20.83%) possessed overall modes that indicated that they were not met. Nine (37.50%) possessed overall modes that indicated that they were partially met and 10 (41.67%) possessed overall modes that indicated that they were fully met. As such, for the Type 2 unit standards, the majority of standards were found to be either partially met or fully met by the respective participants.

Type 3 Unit Standards: Category 2

Table 9 presents the Type 3 standards of the staffing and training category (n=5).

Table 9

Type 3 Standards for the Staff and Training (n=5)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
2.3.9	The unit has formal arrangements to ensure provision of arts therapists e.g. drama therapy, music, art.	One			3	3	Overall, the children admitted to the TLC are provided with weekly Art Therapy and yoga sessions. Swimming is provided every first and fourth term whilst music therapy used to be introduced into the therapeutic programme.
		Two			3		
		Three			3		
		Four			3		
		Five			3		
		Six			3		
		Seven			3		
2.3.12	Young people have access to teachers of specialist subjects e.g. language tutors.	One	1			1	Overall, this service is not accessible within the TLC. In some instances, arrangements can potentially be made to organise specialists externally. The primary school teacher covers this role adequately.
		Two	1				
		Three		2			
		Four	1				
		Five	1				
		Six		2			
		Seven		2			
2.3.13	Young people have access to other education professionals as required *Guidance: Career advisors, educational psychologists etc.*	One		2		2	Overall, children admitted at the TLC have access to special education professionals and educational psychologists from the Western Cape Education Department (WCED) upon request. These requests usually take a while to process and finalise.
		Two		2			
		Three		2			
		Four		2			
		Five	1				
		Six		2			
		Seven			3		

Table 9

Type 3 Standards for the Staff and Training (n=5)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
2.6.9	Non clinical staff have received mental health awareness training *Guidance: This includes teachers, administrators and domestic staff.*	One	1			2	Overall, SPMS and staff development plans are implemented for staff. The teacher, for example, does have access to basic mental health awareness training through DCAP academic meetings and WCED and TLC in-service training. Admin clerks have exposure to courses in mental health awareness but there is no clarity on the specifics of these support programmes.
		Two		2			
		Three		2			
		Four		2			
		Five	1				
		Six	1				
		Seven		2			
2.7.1	Staff members have access to study facilities (including books and journals on site or online) and time to support relevant research and academic activity.	One		2		2	Overall, internet access and access to academic journals is limited to specific staff members (e.g., clinical staff). These are staff members who are non-UCT affiliated staff members. Nonetheless, there is practical ongoing training available for access but time is a constraint.
		Two		2			
		Three	1				
		Four		2			
		Five			3		
		Six		2			
		Seven		2			

Of the five Type 3 unit standards measured, only one (20 %) possessed an overall mode that indicated that it was not met. Three (60 %) possessed overall modes that indicated that they were partially met and one (20%) possessed an overall mode that indicated that it was fully met. As such, for the Type 3 unit standards, the majority of standards were found to be partially met by the respective participants.

Based on the responses and critique of the unit standards for staffing and training, the evaluator identified which standards were deemed to be the highest and lowest met unit standards.

Highest Met Unit Standards of Category 2

The section below illustrates the two highest met unit standards across Category 2.

2.3.9 (Type 3):

The unit has formal arrangements to ensure provision of arts therapists (e.g. drama therapy, music, art).

2.4.2 (Type 2):

The MDT attends business meetings that are held at least monthly

Figure 4. Highest Met Unit Standards of Category 2

Category 3: Access, Admission and Discharge

The Access, Admission and Discharge Category focuses primarily on the availability of appropriate treatment for children referred to the inpatient psychiatric unit; the level of access these children and their parents/carers have; assessment specifics according to the programme; and processes and procedures pertaining to secure discharge of the children after receiving the programme. There are a total of 31 unit standards for this category.

Type 1 Unit Standards: Category 3

Table 10 presents the standards of Category 3 (i.e., access, admission and discharge at the TLC) that are identified as Type 1 (n=20). The individual responses of the participants can be seen in Appendix E.

Table 10
Type 1 Standards for Access, Admission and Discharge (n = 20)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
3.1.1	Clear information is made available, in paper and/or electronic format, to the young people, carers and healthcare practitioners on: • A simple description of the ward/unit and its purpose; • Admission criteria; • Clinical pathways describing access and discharge; • Main interventions and treatments available; • Contact details for the ward/unit and hospital.	One		2		2	The team has identified that, as standard practice, parents/carers and patients are provided with a pre-admission information pack that provides most, but not all, the information listed.
		Two		2			
		Three			3		
		Four		2			
		Five		2			
		Six			3		
		Seven			3		
3.1.2	Unplanned admissions need an initial planning meeting with local services within five working days of admission.	One	1			1	Overall, there is contention to the satisfaction of this unit standard. Some have agreed that the meetings do take place within the timeframe whilst others have not. The local services or referral agents as has been described do not always attend this meeting.
		Two	1				
		Three			3		
		Four		2			
		Five	1				
		Six			3		
		Seven		2			

Table 10 Continued

Type 1 Standards for Access, Admission and Discharge (n = 20)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
3.1.3	Senior clinical staff members make decisions about the young person's admission or transfer. They can refuse to accept young people if they fear that the mix will compromise safety and/or therapeutic activity. *Guidance: Senior clinical staff members include the ward/unit manager or nurse in charge*	One			3	3	Currently, senior clinical staff, along with the input of nursing and multidisciplinary team, frequently makes decisions based on a child's admission. Included in this process are sessional interviews with parents/carers to discuss suitability.
		Two			3		
		Three			3		
		Four			3		
		Five			3		
		Six			3		
		Seven			3		
3.2.1	Young people at severe risk can be admitted as emergencies (i.e. within 24 hours) including out of hours. Units that fail to meet have a plan in place to deal with emergency referrals.	One		2		3	Overall, emergency admissions are generally first referred to the main RCWMCH. The following day they are assessed along with in-depth multidisciplinary team discussions to establish the child's suitability. Emergency admissions are infrequent though and admission becomes difficult if the ward is already full.
		Two			3		
		Three			3		
		Four			3		
		Five			3		
		Six		2			
		Seven			3		
3.2.2	There is a clear process in place for handling situations where agreed bed occupancy levels need to be exceeded.	One	1			2	Different responses were provided. The majority of responses agree that there is a process in place for handling exceeding bed occupancy levels. With a lot of discussion and motivations, children in these positions will either be given day-patient status or be admitted in other settings.
		Two		2			
		Three			3		
		Four		2			
		Five	1				
		Six		2			
		Seven			3		

Table 10 Continued

Type 1 Standards for Access, Admission and Discharge (n = 20)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
3.2.4	The aims of the treatment are discussed with the young person and others involved in care.	One	1			3	Overall, the majority of responses state that the aims of admission are continuously presented and discussed with the children admitted through different platforms, particularly the clinicians, nursing and feedback and discharge meetings.
		Two			3		
		Three			3		
		Four		2			
		Five			3		
		Six			3		
		Seven			3		
3.2.5	Young people have a comprehensive assessment which is started on the day of admission and completed within four weeks. This involves the multi-disciplinary team and includes young people's: Mental health and medication; Psychosocial needs; Strengths and weaknesses; and Views and personal goals.	One	1			3	Overall, as standard practice, a comprehensive assessment process of children referred is conducted at the TLC. However, a notable concern is that it is generally not completed within the timeframe stated due to, for example, difficulties with parent availability for interviewing. Children end up staying longer than necessary as a result.
		Two		2			
		Three			3		
		Four		2			
		Five			3		
		Six			3		
		Seven			3		
3.2.6	All assessments are documented, signed/validated (electronic records) and dated by the assessing practitioner.	One		2		3	Currently, all assessments are documented, signed and dated but not always timeously according to plan. Furthermore, the majority of assessments are not electronically documented (i.e., paper notes).
		Two			3		
		Three			3		
		Four		2			
		Five			3		
		Six		2			
		Seven			3		

Table 10 Continued

Type 1 Standards for Access, Admission and Discharge (n = 20)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
3.2.7	There is a documented admission meeting within one week of the young person's admission. *Guidance: This could take the form of a ward round meeting or a Care Programme Approach meeting (or equivalent).*	One	1			3	With all new children admitted, ward round meetings with the multidisciplinary team take place at the beginning of each week which adheres to the timeframe stated.
		Two			3		
		Three			3		
		Four		2			
		Five			3		
		Six			3		
		Seven			3		
3.2.8	On admission to the ward/unit, or when the young person is well enough, staff members show the young person around.	One		2		3	Currently, as part of standard practice at the TLC, children who are referred and their parents/carers are given a thorough tour of the unit as part of the preadmission process. This allows them to know what to expect prior to admission and for the parents to make a final decision about admission.
		Two			3		
		Three			3		
		Four			3		
		Five			3		
		Six			3		
		Seven			3		
3.3.1	The unit meets the needs of young people from different ethnic, cultural and religious backgrounds.	One		2		2	Overall, the unit and staff within it provide their best to accommodate and adapt conventional ways of working to meeting the needs of children from diverse and multicultural backgrounds, given its importance to the respect, dignity and care of the children admitted. However, not all staff may have adequate cultural competency which needs to be attended to.
		Two		2			
		Three			3		
		Four		2			
		Five			3		
		Six		2			
		Seven			3		

Table 10 Continued

Type 1 Standards for Access, Admission and Discharge (n = 20)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
3.3.3	The ward/unit has access to interpreters and the young person's relatives are not used in this role unless there are exceptional circumstances.	One	1			1	Overall, there is access to interpreters via the main hospital RCWMCH, but this service is rarely used. This is because many of the staff members are competent in more than one South African language and the fact that parents/carers may be requested to help due to time constraints.
		Two		2			
		Three			3		
		Four		2			
		Five	1				
		Six	1				
		Seven			3		
3.5.1	During assessment staff involves parents/carers where appropriate.	One			3	3	Overall, parents/carers and/or legal guardians are almost always included in the assessment process. They are involved history taking and providing insight into their children's behaviour at home. Depending on the nature of some assessments by staff, they may or may not be included.
		Two			3		
		Three			3		
		Four			3		
		Five			3		
		Six			3		
		Seven			3		
3.5.3	The young person's carer is contacted by a staff member (with young person's consent) to notify them of the admission and to give them the ward/unit contact details.	One	1			3	Due to the age appropriateness of the child, nursing management contacts the parents/carers to provide them with admission details.
		Two			3		
		Three			3		
		Four	1				
		Five		2			
		Six		2			
		Seven			3		

Table 10 Continued

Type 1 Standards for Access, Admission and Discharge (n = 20)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
3.6.1	The inpatient team invites a community team representative to attend and contribute to relevant meetings e.g. CPA, discharge planning.	One		2		3	Overall, representatives of outpatient services, referrers, external social workers and teachers, representatives from the department of education are invited to provide their input in relevant meetings. However, they do not always attend.
		Two			3		
		Three			3		
		Four		2			
		Five			3		
		Six			3		
		Seven			3		
3.6.3	When a young person transfers to adult services, unit staff invite adult services and other involved agencies to a joint review to ensure an effective handover takes place and there is a protocol for collaborative working.	One	1			1	Only children under the age of 13 are admitted into the TLC, therefore would be applicable for transfers to adult units in this context. However, these children may be transferred accordingly to appropriate outpatient services.
		Two	1				
		Three		2			
		Four	1				
		Five			3		
		Six		2			
		Seven			3		
3.6.4	A letter setting out a clear discharge plan, which the young person takes home with them, is sent to all relevant parties before or on the day of discharge. The plan includes details of: • Care in the community/aftercare arrangements;• Crisis and contingency arrangements including details of who to contact; • Medication; • Details of when, where and who will follow up with the young person	One	1			2	Overall, discharge plans are completed at the TLC, but not always fully and timeously for the day of discharge. Furthermore, standard practice permits the plan to be distributed to the child's parents/carers, not the children.
		Two		2			
		Three		2			
		Four		2			
		Five			3		
		Six		2			
		Seven			3		

Table 10 Continued

Type 1 Standards for Access, Admission and Discharge (n = 20)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
3.6.6	The young person and their carer (with young person's consent) are invited to a discharge meeting and are involved in decisions about discharge plans.	One		2		2	Discharge meetings at the TLC occur according to plan and schedule. However, parents/carers are usually the ones invited, not the children.
		Two		2			
		Three		2			
		Four		2			
		Five			3		
		Six		2			
		Seven			3		
3.6.7	There is a procedure in place for taking action on delayed discharge.	One		2		2	Despite uncertainty in the responses provided about a formalised procedure for delayed discharge, an apparent standard operating procedure for escalating social and educational placement delays discharge.
		Two		2			
		Three		2			
		Four		2			
		Five	1				
		Six	1				
		Seven			3		
3.6.9	The team makes sure that young people who are discharged from hospital to the care of the community team have arrangements in place to be followed up within one week of discharge, or within 48 hours of discharge if they are at risk. Young people should be aware of the follow up arrangements.	One	1			2	Overall, children who are discharged usually attended follow-up sessions beyond the timeframe of week post-discharge. This may be due to the workload within the community. If they are at risk when discharged, a follow-up appointment is secured.
		Two		2			
		Three			3		
		Four	1				
		Five		2			
		Six		2			
		Seven			3		

Of the 20 Type 1 unit standards measured, three (15 %) possessed overall modes that indicated that they were not met. Seven (35 %) possessed overall modes that indicated that they were partially met and a total of 10 (50 %) possessed overall modes that indicated that they were fully met. As such, for the Type 1 unit standards, the majority of standards were found to be fully met by the respective participants despite the narrow gap between those partially met.

Type 2 Unit Standards: Category 3

Table 11 presents the Type 2 standards of the access, admission and discharge category (n=10).

Table 11
Type 2 Standards for Access, Admission and Discharge (n = 10)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
3.1.4	The unit formally records all referrals with respect to race, gender, home area and disability, and this is reviewed annually.	One	1			3	Annual reviews usually record this information of referrals. It does not, however, include race nor is it reviewed annually.
		Two			3		
		Three			3		
		Four		2			
		Five		2			
		Six		2			
		Seven			3		
3.2.3	There is a system in place to monitor and address delays in admission and treatment which is reviewed annually.	One	1			3	Overall, there appears to be no formal system in place, but TLC review meetings for referral, preadmission and assessments potentially provide means to identify any delays in admission.
		Two			3		
		Three			3		
		Four			3		
		Five			3		
		Six	1				
		Seven			3		

Table 11 Continued

Type 2 Standards for Access, Admission and Discharge (n = 10)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
3.3.2	The service actively supports families to overcome barriers to access.	One	1			3	Overall, there is some degree of support and assistance for families of admitted children, despite the difficulties in balancing and high work load of the unit. Assistance with access to social support and transport money are examples of aid and assistance provided.
		Two			3		
		Three			3		
		Four			3		
		Five			3		
		Six			3		
		Seven		2			
3.4.1	Where young people are not admitted to the service, the reasons are explained to the referrer, and young people and parents/carers where appropriate.	One		2		3	Overall, feedback for reasons of non-admission, as part of the assessment process, is generally carried out. This is provided to the parents/carers, not the children. Furthermore, there is concern as the reasoning should be communicated via a written document and verbally. Notably, referrers are not always provided with this feedback, leading them to have to follow-up.
		Two		2			
		Three			3		
		Four		2			
		Five			3		
		Six			3		
		Seven			3		
3.5.2	Carers are advised on how to access a statutory carers' assessment, provided by an appropriate agency/All families have access to an assessment of their needs where appropriate.	One	1			1	Overall, this process does form part of standard practice at the TLC. When the need arises and is appropriate, parents and carers may be sent to appropriate social services.
		Two	1				
		Three			3		
		Four	1				
		Five	1				
		Six		2			
		Seven			3		

Table 11 Continued

Type 2 Standards for Access, Admission and Discharge (n = 10)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
3.6.2	Discharge planning is initiated at the first multidisciplinary team review and an estimated length of stay is established.	One		2		2	Overall, due to a child's length of admission and treatment progress, it is difficult setting an exact date for discharge at the first case presentation occurring a month after admission. Usually it is pushed for the end of term but again, it is difficult based on the above factors.
		Two		2			
		Three			3		
		Four		2			
		Five			3		
		Six		2			
		Seven			3		
3.6.5	A written comprehensive summary is produced and distributed within ten days of discharge.	One	1			2	Overall, given that preparation and input is collated from many multidisciplinary team members, the discharge summary - despite being standard practice - is usually only ready after the 10-day period.
		Two		2			
		Three			3		
		Four		2			
		Five			3		
		Six		2			
		Seven		2			
3.6.9	Young people are supported by staff members, where required, to access care from other physical health services to meet their needs. This includes: - Accident and emergency; - Social services; - Local and specialist mental services (e.g., liaison, eating disorders and rehabilitation) - Secondary physical healthcare	One			3	3	Children admitted are certainly supported, in conjunction with the main RCWMCH, when it comes to access care from physical health services and needs being met by other medical specialties. Family members are support with regards to this access. Appointments and secure transportation are all organised.
		Two			3		
		Three			3		
		Four			3		
		Five			3		
		Six		2			
		Seven			3		

Table 11 Continued

Type 2 Standards for Access, Admission and Discharge (n = 10)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
3.6.10	When young people are transferred between wards/units there is a handover which ensures that the new team has an up to date care plan and risk assessment.	One	1			1	Overall, this process rarely occurs given that the TLC is the only child inpatient psychiatric unit offering careful assessment and monitoring. Nonetheless, up to date care plans and risk assessment are provided.
		Two		2			
		Three		2			
		Four	1				
		Five	1				
		Six			3		
		Seven			3		
3.6.11	The team follows a joint working protocol/care pathway with the Home Treatment/Crisis Resolution team in wards/units that have access to one. *Guidance: This includes the team inviting the Home Treatment Team to attend ward rounds, to screen for early discharge, to undertake joint acute care reviews and to jointly arrange supported leave.*	One	1			1	Overall, this is not fully applicable to the TLC context as child mental health services do not include Home Treatment/Crisis Resolution teams for access. Carers from children's homes would be involved in treatment and management planning, including home visitation.
		Two	1				
		Three		2			
		Four	1				
		Five			3		
		Six		2			
		Seven		2			

Of the 10 Type 2 unit standards measured, three (30 %) possessed overall modes that indicated that they were not met. Two (20 %) possessed overall modes that indicated that they were partially met and a total of five (50 %) possessed overall modes that indicated that they were fully met. As such, for the Type 2 unit standards, the majority of standards were found to be fully met by the respective participants.

Type 3 Unit Standards: Category 3

Table 12 presents the Type 3 standards of the access, admission and discharge category (n=1).

Table 12
Type 3 Standards for Access, Admission and Discharge (n = 1)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
3.6.8	The team provides information, signposting and encouragement to young people to access local organisations such as: Voluntary organisations; Community centres; Local religious/cultural groups; Peer support networks; and Recovery colleges.	One		2		2	Overall, parents/carers are predominantly provided with information entailing these details given the age of the children. Furthermore, community organisations are short in number and access.
		Two		2			
		Three			3		
		Four		2			
		Five		2			
		Six	1				
		Seven			3		

The Access, Admission and Discharge Category only has one Type 3 unit standard. As evidenced in Table 12, this unit standard possessed an overall mode that indicated that it was partially met.

Based on the responses and critique of the unit standards for access, admission and discharge, the evaluator identified which standards were deemed to be the highest met unit standards.

Highest Met Unit Standards of Category 3

The section below illustrates the highest met unit standards across Category 3.

3.1.3 (Type 1):

Senior clinical staff members make decisions about the young person's admission or transfer. They can refuse to accept young people if they fear that the mix will compromise safety and/or therapeutic activity.

3.5.1 (Type 1):

During assessment staff involves parents/carers where appropriate.

Figure 5. Highest Met Unit Standards in Category 3.

Category 4: Care and Treatment

The Care and Treatment Category refers to aspects of the assessment of and interventions provided to children who are admitted for the TLC's therapeutic programme. Underlying this programme of treatment is the care plan development for the children, along with educational, outcome measurement and nutrition components that play a large part in the care of the children. There are a total of 64 unit standards for this category. The following stakeholders (n=9) were asked to provide input on the TLC's environment and facilities in relations to the QNIC standards: three members of the psychiatry department; two members of the educational component; one member of the psychology department; and three members of the nursing department. The responses from the two participants of the educational component were only included for unit standards 4.6.1 to 4.6.12 as these standards referred specifically to the education and schooling of the children admitted to the TLC. Furthermore, any and all other unit standards could not be answered by these two participants due to inapplicability to their field and position within the TLC unit.

Type 1 Unit Standards: Category 4

Table 13 presents the standards of Category 4 (i.e., care and treatment at the TLC) that are identified as Type 1 (n=48). The individual responses of the participants can be seen in Appendix F.

Table 13

Type 1 Standards for the Care and Treatment (n = 48)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
4.1.1	Young people have a risk assessment which is completed using a formal tool and includes a comprehensive assessment of: risk to self; risk to others; risk from others.	One			3	3	Overall, this process of a comprehensive risk assessment takes place as standard practice during admission of the children to the TLC unit. No further details is provided on its level of comprehensiveness.
		Two			3		
		Three			3		
		Four			3		
		Five			3		
		Six			3		
		Seven			3		
4.1.2	Risk assessments and management plans are updated according to clinical need and as part of care planning meetings at a minimum.	One		2		3	Again, these processes are completed as standard clinical practice at the TLC. Management plans are reportedly reviewed weekly at ward round meetings whilst risk assessments receiving ongoing review.
		Two			3		
		Three			3		
		Four			3		
		Five			3		
		Six			3		
		Seven			3		
4.1.3	Young people have a comprehensive physical health review. This is started within 4 hours of admission and is completed within 1 week, or prior to discharge.	One			3	3	There were very little detailed responses to this unit standards satisfaction. Evidence for its completion in terms of a physical health review at the TLC is located in clinical notes which outline the examination and nursing process procedures. It is unclear whether EEG's are carried out routinely.
		Two		2			
		Three			3		
		Four			3		
		Five			3		
		Six					
		Seven			3		

Table 13 Continued

Type 1 Standards for the Care and Treatment (n = 48)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
4.1.4	If part or all of the examination is refused, the reason why has been recorded and repeated attempts has been made to complete this process.	One		2		3	Overall, when such a scenario occurs, the reasons for the refusal, which primarily come from the parents/carers, are documented at the TLC and kept in patient folders.
		Two			3		
		Three			3		
		Four			3		
		Five			3		
		Six			3		
		Seven			3		
4.1.5	Young people have follow-up investigations and treatment when concerns about their physical health are identified during their admission. *Guidance: This is undertaken promptly and a named individual is responsible for follow-up. Advice may be sought from primary or secondary physical healthcare services.*	One		2		3	Overall, this is completed as standard practice. The applicable specialists would be contacted and sought out for examination. If there are delays, it is usually due to waiting lists.
		Two			3		
		Three			3		
		Four		2			
		Five		2			
		Six			3		
		Seven			3		
4.2.1	Young people are offered pharmacological and psychological interventions in accordance with the evidence base and good practice.	One		2		2	Overall, the TLC tries their best to secure evidence based treatment and interventions within pharmacological and psychological regards but it is difficult due to the level of skill sets.
		Two		2			
		Three			3		
		Four		2			
		Five		2			
		Six			3		
		Seven			3		

Table 13 Continued

Type 1 Standards for the Care and Treatment (n = 48)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
4.2.2	Inpatient services have a range of interventions available. These include: Medication; Individual therapy (e.g. psychotherapy, CBT etc.) provided by a qualified therapist; Therapeutic Group Work; Family Therapy; Occupational Therapy; Parents/carers feel supported by the ward	One		2		3	Overall, the TLC provides the majority of these services as part of their broad unit therapeutic programme in affiliation with the main hospital RCWMCH. Some aspects, as pointed out, are not fully satisfied such as family therapy services from a registered family therapist and insufficient services provided from Occupational Therapists.
		Two			3		
		Three			3		
		Four			3		
		Five			3		
		Six			3		
		Seven			3		
4.3.1	Every young person has a personalised structured timetable of meaningful activities.	One		2		3	Overall, the TLC implements as patient therapeutic programme which would include weekly, weekend and holiday programmes. The programme is standardised for all children admitted but can adapted based on individual needs and therapy as orientated.
		Two			3		
		Three			3		
		Four		2			
		Five			3		
		Six		2			
		Seven			3		
4.3.2	There are a range of accessible activities are provided everyday including evenings, weekends and bank holidays. *Guidance: Activities which are provided during working hours, Monday- Friday, are timetabled.*	One			3	3	As stated previously, the TLC does possess weekly, weekend and holiday programmes. Responses suggest the weekend programmes have been unstructured whilst holidays programmes are more structured and detailed to work around the child's clinical needs.
		Two			3		
		Three			3		
		Four			3		
		Five			3		
		Six		2			
		Seven			3		

Table 13 Continued

Type 1 Standards for the Care and Treatment (n = 48)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
4.3.2*	Young people and the team can obtain a second opinion if there is doubt, uncertainty or disagreement about the diagnosis, formulation or treatment.	One		2		3	Overall, patients are seldom in a position to request second opinions based on their age and developmental stage. The TLC team has good relations established with the clinicians which can be requested from Outpatient service colleagues and cross platform colleagues in other psychiatry services (e.g., Lentegeur hospital). However, it cannot always be attained.
		Two			3		
		Three		2			
		Four			3		
		Five			3		
		Six		2			
		Seven			3		
4.3.2*	Where appropriate, young people are actively involved in shared decision-making about their mental and physical health care, treatment, discharge planning and are supported in self-management.	One	1			2	Overall, this is completed by the team at the TLC to a certain degree as appropriate. Children's needs are always taken into consideration but many of them, based on their developmental stage, cannot independently engage with such decision processes. Their views are therefore not actively sought out.
		Two			3		
		Three		2			
		Four	1				
		Five		2			
		Six		2			
		Seven			3		
4.3.2*	Young people and parents/carers are supported by staff members, before (to prepare), during (to understand and contribute) and after (to feedback outcomes) any formal review of their care.	One	1			3	Overall, there does appear to be some contention with the satisfaction of this unit standard. Case managers, doctors, nurses on call and relevant teams members liaise with and support the parents/carers and children admitted on an ongoing basis where the former would be more involved. It is uncertain where the formal review of their care would fall in.
		Two		2			
		Three			3		
		Four		2			
		Five			3		
		Six		2			
		Seven			3		

Table 13 Continued

Type 1 Standards for the Care and Treatment (n = 48)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
4.3.3	The team gives targeted lifestyle advice and provides health promotion activities for young people. This may include: physical exercise advice; healthy eating advice; smoking cessation advice.	One		2		3	Overall, children admitted are provided with lifestyle advice and health promotion activities from various platforms, such as nursing and in-house teaching. More is needed however. Some of the content would not be as relevant to the children admitted given their age (e.g., smoking cessation).
		Two			3		
		Three			3		
		Four			3		
		Five		2			
		Six		2			
		Seven			3		
4.3.4	Young people's preferences are taken into account during the selection of medication, therapies and activities and acted upon as far as possible.	One	1			3	Overall, the team at the TLC does their best to take children's preference to the programme into account as standard practice. It proves difficult given their age and developmental stage.
		Two			3		
		Three			3		
		Four			3		
		Five					
		Six		2			
		Seven			3		
4.3.5	Young people and parents/carers have access to key members of the MDT outside of planned meetings to review their progress.	One		2		3	Overall, senior registrars and a child's assigned case manager routinely/regularly check in and support the child and his/her parents/carers.
		Two			3		
		Three		2			
		Four		2			
		Five			3		
		Six			3		
		Seven			3		

Table 13 Continued

Type 1 Standards for the Care and Treatment (n = 48)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
4.4.1	All young people have a documented diagnosis and/or clinical formulation which is discussed with them. *Guidance: The formulation includes the presenting problem and predisposing, precipitating, perpetuating and protective factors as appropriate.*	One	1			3	Overall, formulations for the purposes of case presentations are put together and discussed with the parents/carers and children (to a certain degree). It is unclear if this is routinely done despite being identified as standard practice.
		Two		2			
		Three			3		
		Four		2			
		Five			3		
		Six			3		
		Seven			3		
4.5.1	Care of all young people takes place within a formal Care Programme Approach framework or local equivalent.	One		2		3	Despite some uncertainty, currently, detailed discharge summaries with recommendations are provided for ongoing care. Furthermore, treatment is formulated to support each child's need in their management plan.
		Two					
		Three			3		
		Four		2			
		Five			3		
		Six			3		
		Seven			3		
4.5.2	Young people are facilitated and supported to prepare for any formal review of their care. *Guidance: an advocate may help young people to do this.*	One	1			2	Overall, children are included as appropriate as possible. This is usually dependent on their age and developmental stage. It does not mean that this preparation of involvement cannot be done.
		Two	1				
		Three		2			
		Four		2			
		Five			3		
		Six		2			
		Seven			3		

Table 13 Continued

Type 1 Standards for the Care and Treatment (n = 48)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
4.5.3	Young people and parents/carers are supported to contribute and express their views during reviews.	One		2		3	Overall, in terms of case presentations and parent/carer feedback meetings, there is a lot of contribution and information distributed to the parents/carers, more so than the children despite their views taken into consideration.
		Two			3		
		Three			3		
		Four	1				
		Five			3		
		Six		2			
		Seven			3		
4.5.4	Young people and parents/carers know who is coordinating their care on the unit and how to access them if they have any questions.	One		2		3	Overall, according to evidence from clinical and nursing notes, for the most part, children admitted are aware of who their case manager and special nurse is although this is not always the case as the children may forget. They are aware of how to meet them.
		Two			3		
		Three			3		
		Four		2			
		Five			3		
		Six			3		
		Seven			3		
4.5.4*	The team reviews and updates care plans according to clinical need or at a minimum frequency of a month. *Guidance: The care plan clearly outlines: Agreed intervention strategies for physical and mental health; Measurable goals and outcomes; Any advance directives or statements that the patient has made; Crisis and contingency plans; Review dates and discharge framework.*	One		2		2	Overall, some aspects of team reviews and updates are deliberated in weekly ward round meetings. Furthermore, case presentations do not occur on a monthly basis.
		Two		2			
		Three			3		
		Four		2			
		Five			3		
		Six		2			
		Seven			3		

Table 13 Continued

Type 1 Standards for the Care and Treatment (n = 48)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
4.5.5	Parents and carers are offered individual time with staff members, within 48 hours of the patient's admission to discuss concerns, family history and their own needs.	One	1			2	Overall, parents/carers are able to engage with and discuss concerns with staff members (e.g., admitting doctor) as part of the admission process. More concerns can be discussed in history taking sessions. However, the rate at which individual sessions/meetings with specific staff members is inconsistent.
		Two		2			
		Three		2			
		Four		2			
		Five			3		
		Six			3		
		Seven			3		
4.5.6	The practitioner develops and reviews the care plan collaboratively with the young person and their carer (with young person consent).	One		2		2	Overall, as standard practice, the TLC staff members try to include children admitted and their parents/carers in care planning, more so the latter. There is some uncertainty surrounding formal care plans set out.
		Two		2			
		Three			3		
		Four		2			
		Five					
		Six		2			
		Seven			3		
4.5.7	All young people sign their care plan.	One	1			1	There, reportedly, is no formal care plan that the children admitted are in any position to sign. Care plans are signed by case management and nursing care plans are signed by the nursing staff respectively.
		Two	1				
		Three	1				
		Four	1				
		Five	1				
		Six	1				
		Seven	1				

Table 13 Continued

Type 1 Standards for the Care and Treatment (n = 48)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
4.5.8	The young person and their carer (with young person consent) are offered a copy of the care plan and the opportunity to review this.	One	1			1	As stated in the previous unit standard feedback. Parents/carers are reportedly provided with copies of feedback forms outlining care plans but no copies are distributed to the children admitted individually. They can be shared to them by the respective parents/carers accordingly.
		Two	1				
		Three	1				
		Four	1				
		Five	1				
		Six	1				
		Seven		2			
4.5.10	If a local authority has parental responsibility as a result of a care order, the hospital should obtain the named social worker's consent where necessary and consult on the young person's care plan.	One		2		2	Overall, social workers and members of the Department of Social Development as required are actively engaged with on this matter but not to the full extent of which the care plan is being highlighted here.
		Two		2			
		Three			3		
		Four		2			
		Five		2			
		Six			3		
		Seven			3		
4.6.1	The unit provides the core educational subjects: Maths, English and Science.	One		2		2	Overall, according to the curriculum, the subjects focused on at the TLC schooling component are English, Afrikaans, Math, Social Science and Life Skills. Science is not taught or continued.
		Two		2			
		Three		2			
		Four		2			
		Five		2			
		Six		2			
		Seven		2			
		Eight		2			
		Nine		2			

Table 13 Continued

Type 1 Standards for the Care and Treatment (n = 48)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
4.6.3	Where the unit caters for young people over the age of 16, young people are able to continue with education.	One	1			1	This is not applicable to the TLC unit as children admitted are under the age of 13 years.
		Two	1				
		Three	1				
		Four	1				
		Five	1				
		Six	1				
		Seven	1				
		Eight	1				
		Nine	1				
4.6.4	Teaching staff complete an assessment of each young person's educational needs which is reviewed at each CPA review (or local equivalent).	One			3	3	Overall, there is an importance upheld at the TLC for children to continue their education as much as possible which can be assessed. However, some children are unable to work effectively making it difficult to finalise reports with quantitative data that captures their academic level. Advice from curriculum advisors are sought.
		Two			3		
		Three		2			
		Four			3		
		Five		2			
		Six			3		
		Seven		2			
		Eight		2			
		Nine			3		

Table 13 Continued

Type 1 Standards for the Care and Treatment (n = 48)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
4.6.5	All young people have a personal education plan which reflects the focus on wider progress and wellbeing in education in addition to academic progress. *Guidance: Mental Health Functioning in Education can be used to show focus on wider progress.*	One		2		3	Overall, this is usually dependent on the academic and developmental level of the children. Their specified goals are integrated into their learning accordingly within the classroom as the MDT documents their progress.
		Two					
		Three			3		
		Four			3		
		Five					
		Six			3		
		Seven					
		Eight					
		Nine		2			
4.6.6	If the young person is receiving education, educational staff at the unit must liaise with the young person's own school in order to maintain continuity of education provision.	One			3	3	Overall, liaison between the teaching staff and school of children admitted is maintained to the best of both parties abilities. This can be difficult as they are sometimes unresponsive with sending work assignments and simply communicating. In such instances, the curriculum advisor is asked to step in and assist with this deficit. A good relationship with the schools and school governing bodies is sustained.
		Two		2			
		Three		2			
		Four			3		
		Five		2			
		Six			3		
		Seven			3		
		Eight			3		
		Nine			3		

Table 13 Continued

Type 1 Standards for the Care and Treatment (n = 48)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
4.6.7	Where young people are returning to their local educational facility after discharge, education and unit staff support the young people with their reintegration.	One		2		3	Overall, the TLC team tries to support children's bridging and reintegration, with collaboration from their respective school and parents/carers. Some aspects of the reintegration has been affected such as the positioning of nurses and the fact that they cannot work offsite whilst the child bridges. Reintegration plays a major part in the aims of the TLC post discharge.
		Two			3		
		Three			3		
		Four			3		
		Five			3		
		Six			3		
		Seven			3		
		Eight			3		
		Nine			3		
4.6.10	Teachers contribute to multi-disciplinary meetings.	One			3	3	Overall, the teacher attends and contributes to regular team meetings such as ward round, goals and strategies, admin meetings and case presentations. Lately, there have been concerns surrounding the level of collaboration in communication between the school and the child where the teaching staff may not be consistently informed.
		Two			3		
		Three		2			
		Four			3		
		Five			3		
		Six			3		
		Seven			3		
		Eight			3		
		Nine			3		

Table 13 Continued

Type 1 Standards for the Care and Treatment (n = 48)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
4.6.11	When young people are absent without leave, the team (in accordance with local policy): • Activates a risk management plan; • Makes efforts to locate the young people; • Alerts carers, people at risk and the relevant authorities	One			3	3	Overall, despite hardly occurring, relevant stakeholders would be contacted as required. Usually, children admitted would sign in from the weekend on Sundays, where if they haven't signed in by 16h00 pm, their parents/carers will be contacted for clarity. Reasons and solutions for such situations need to be developed.
		Two			3		
		Three			3		
		Four			3		
		Five			3		
		Six			3		
		Seven			3		
		Eight			3		
		Nine			3		
4.6.12	The unit must be part of an education organisation that is a registered examination centre.	One		2		3	Within the context of the TLC, this registered examination centre would incorporate the Red Cross Hospital Primary School which is registered with the Western Cape Education Department, as is the teacher appointed.
		Two					
		Three			3		
		Four			3		
		Five					
		Six			3		
		Seven					
		Eight		2			
		Nine		2			

Table 13 Continued

Type 1 Standards for the Care and Treatment (n = 48)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
4.7.1	Clinical outcome measurement data is collected at two time points (admission and discharge as a minimum and at clinical reviews where possible (e.g. HoNOSCA, SDQ etc).	One		2		2	Overall, SDQ questionnaires are administered at preadmission and discharge. C-GAS Scores are administered at case presentations and discharge. However, they are not consistently administered by staff members.
		Two		2			
		Three			3		
		Four		2			
		Five		2			
		Six	1				
		Seven		2			
4.7.2	Outcome measurement tools are completed from the perspective of staff, young people and/or parents/carers.	One		2		2	Overall, it is predominantly the parents/carers who completed the prescribed outcomes measures, such as the SNAP Rating Scale. Children's responses are usually acquired qualitatively and through interviews.
		Two		2			
		Three			3		
		Four		2			
		Five		2			
		Six	1				
		Seven		2			
4.8.1	Young people are provided with meals which offer choice, address nutritional/balanced diet and specific dietary requirements and which are also sufficient in quantity. Meals are varied and reflect the individual's cultural and religious needs.	One		2		2	Overall, children admitted are provided with the same food supplied from the hospital which is prepared safely and does provide balanced dieting, individual clinical, nutritional, cultural/religious dietary requirements. Personal preference is usually not considered nor is the food always nutritious depending on the children's reception to it.
		Two			3		
		Three			3		
		Four			3		
		Five	1				
		Six		2			
		Seven		2			

Table 13 Continued

Type 1 Standards for the Care and Treatment (n = 48)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
4.9.1	The team develops a leave plan jointly with the young person and parent/carer that includes: • A risk assessment and risk management plan that includes an explanation of what to do if problems arise on leave; • Conditions of the leave; • Contact details of the ward/unit.	One		2		3	Overall, leave plans are developed and discussed with the parents/carers indicating the start and end of leave dates, which includes a management plan. The children admitted are more informed than engaged with about it.
		Two			3		
		Three			3		
		Four			3		
		Five			3		
		Six			3		
		Seven			3		
4.9.4	Young people have their medications reviewed at least weekly. Medication reviews include an assessment of therapeutic response, safety, side effects and adherence to medication regime. *Guidance: Side effect monitoring tools can be used to support reviews.*	One			3	3	Overall, medication is reviewed daily during 08h00am feedback meeting with nursing and psychiatry and weekly at ward round meetings. Evidence of these review tools include the stimulant medication side effects rating scale.
		Two					
		Three			3		
		Four			3		
		Five			3		
		Six					
		Seven			3		
4.9.5	When young people experience side effects from their medication, this is engaged with and there is a clear care plan in place for managing this.	One			3	3	Overall, there are strict precautions in place to deal with such matters related to medication side effects. Specifically, the symptoms are discussed with the registrar on call and multidisciplinary team at the TLC.
		Two					
		Three			3		
		Four			3		
		Five			3		
		Six			3		
		Seven			3		

Table 13 Continued

Type 1 Standards for the Care and Treatment (n = 48)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
4.9.6	The team follows a policy when prescribing and dispensing PRN (i.e. as required) medication.	One	1			3	Overall, there appears to be some contention with the satisfaction of this unit standard. Reviews are done daily to check progress of PRN meds given as recorded in inpatient medication prescription sheets. However, there is suggestion that no formal policy on PRN medication is present.
		Two					
		Three			3		
		Four	1				
		Five			3		
		Six			3		
		Seven			3		
4.9.8	The safe use of high risk medication is audited, at least annually and at a service level. *Guidance: This includes medications such as lithium, high dose antipsychotic drugs, antipsychotics in combination, benzodiazepines.*	One	1			1	Currently, no audits are consistently conducted at this level within the TLC as reported.
		Two					
		Three			3		
		Four	1				
		Five					
		Six	1				
		Seven		2			
4.9.9	Young people with poor personal hygiene have a care plan that reflects their personal care needs. *Guidance: This could include encouragement to have regular showers and to shave, referral to a dentist for oral dentition, referral to a podiatrist for foot care.*	One		2		3	Overall, nursing care plans and process notes, along with referral notes are good sources of evidence. Aspects that deal with care of the children admitted are regularly discussed in ward round and goals and strategies meetings. Supervised washing takes place according to clinical need as the children are encouraged to sustain good self-care.
		Two			3		
		Three			3		
		Four			3		
		Five			3		
		Six			3		
		Seven			3		

Table 13 Continued

Type 1 Standards for the Care and Treatment (n = 48)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
4.9.10	The ward/unit has a policy for the care of young people with dual diagnosis that includes: Liaison and shared protocols between mental health and substance misuse services to enable joint working; Drug/alcohol screening to support decisions about care/ treatment options; Liaison between mental health, statutory and voluntary agencies.	One	1			2	Overall, the TLC rarely presents cases of children with dual diagnoses, particularly those in line with the specifics of added substance use. This is due to the young age of the children admitted. Support and referrals may be provided in such rare cases but no dual diagnoses treatment is offered.
		Two		2			
		Three			3		
		Four		2			
		Five					
		Six		2			
		Seven	1				
4.9.11	Long-stay young people who are prescribed mood stabilisers or antipsychotics are reviewed at the start of treatment (baseline), at 3 months and then annually unless a physical health abnormality arises. The clinician monitors information about the young person.	One		2		3	There were very little responses to extrapolate on. These aspects may be routinely checked but not all are covered.
		Two					
		Three			3		
		Four		2			
		Five					
		Six			3		
		Seven			3		

Table 13 Continued

Type 1 Standards for the Care and Treatment (n = 48)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
4.9.12	Young people are told about the level of observation that they are under, how it is instigated, the review process and how their own perspectives are taken into account.	One	1			3	Overall, these children are at varying developmental and cognitive stages and levels. They are informed more depending on these factors but not completed engaged with. It is informed at a level of which they can comprehend.
		Two			3		
		Three			3		
		Four		2			
		Five		2			
		Six			3		
		Seven			3		
4.9.13	Young people are treated with compassion, dignity and respect. *Guidance: This includes respect for a young person's race, age, sex, gender reassignment, marital status, sexual orientation, maternity, disability and social background.*	One			3	3	Overall, it would be concerning if this unit standard was not being met of which it would be dealt with accordingly. Many regulations charter the carrying out of this unit standard (e.g., Patient Rights Charter and HPCSA regulations). The ethos of being polite to other and respecting others in a safe and secure manner is constantly reinforced.
		Two			3		
		Three			3		
		Four			3		
		Five			3		
		Six			3		
		Seven			3		

Note. The unit standards that are marked with an * are duplicate standards from the updated and revised standards post the 2016 reviews. These revisions are either based on the type status or simply new unit standards that have been added to the overall checklist with the same unit standard number.

Of the 48 Type 1 unit standards measured, four (8.33 %) possessed overall modes that indicated that they were not met. Twelve (25 %) possessed overall modes that indicated that they were partially met and a total of 32 (66.67 %) possessed overall modes that indicated that they were fully met. As such, for the Type 1 unit standards, the majority of standards were found to be fully met by the respective participants by a notably large margin.

Type 2 Unit Standards: Category 4

Table 14 presents the Type 2 standards of the care and treatment category (n=14).

Table 14

Type 2 Standards for the Care and Treatment (n = 14)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
4.5.9	Each young person has a pre-arranged session with their key worker at least once a week to discuss progress, care plans and concerns.	One	1			1	Overall, there is a case management system in place, along with special time sessions allocated by nursing. The child admitted would not meet with their case manager weekly but would the senior registrar.
		Two	1				
		Three			3		
		Four	1				
		Five	1				
		Six			3		
		Seven		2			
4.5.11	When a care order is in place the Local Authority is asked to confirm who should be consulted about treatment decisions and other aspects of the child's care plan.	One				3	Overall, this is routinely conducted by the relevant social work department representatives.
		Two			3		
		Three			3		
		Four			3		
		Five					
		Six			3		
		Seven			3		
4.6.2	The unit provides a broad and balanced curriculum that is suitable and flexible, appropriate to the students' needs.	One			3	3	Overall, the curriculum integrated into the TLC therapeutic programme is flexible and adaptive to individual needs especially with the implementation of O.T, Art Therapy, Swimming and Yoga.
		Two			3		
		Three			3		
		Four			3		
		Five			3		
		Six			3		
		Seven			3		
		Eight			3		
		Nine			3		

Table 14 Continued

Type 2 Standards for the Care and Treatment (n = 14)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
4.6.8	The educational staff maintain communication with the young peoples' parents/carers, e.g. providing progress reports for each CPA review.	One		2		3	Overall, parents/carer are well communicated and liaised with from educational staff as information is disseminated to them and their involvement plays a crucial role in their commitment to the child's continuation of education. Responsiveness from parents/carers can be difficult at times.
		Two			3		
		Three			3		
		Four			3		
		Five			3		
		Six			3		
		Seven			3		
		Eight			3		
		Nine			3		
4.6.11	Teachers and nursing staff have a handover at the beginning and end of each school day.	One	1			2	Overall, there is regular handover between nursing and teaching staff, as standard practice. No specific meeting is scheduled in the beginning and end of each day however. Information may be enquired and shared between the nursing and teaching staff should they deem it important regarding the children.
		Two		2			
		Three		2			
		Four		2			
		Five		2			
		Six		2			
		Seven		2			
		Eight		2			
		Nine	1				
4.7.3	Individual outcome measurement data is discussed with the young person as part of their care planning e.g. Goal based outcomes.	One	1			1	Overall, this feedback provided to the children admitted is inconsistently done (i.e., not a routine basis).
		Two	1				
		Three		2			
		Four	1				
		Five	1				
		Six	1				
		Seven		2			

Table 14 Continued

Type 2 Standards for the Care and Treatment (n = 14)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
4.7.4	Outcome data is used as part of service management, staff supervision and development.	One	1			1	Overall, this process used to be conducted more routinely. Currently, there is a box present at the TLC for complaints and compliment forms to be submitted by parents/carers which are forwarded to Human Resources. However, feedback is not always followed up on.
		Two	1				
		Three			3		
		Four	1				
		Five		2			
		Six	1				
		Seven		2			
4.7.5	Information from outcome measurement is fed back to the whole staff team, users and commissioners.	One	1			2	Overall, some outcome information on the children admitted (e.g., SNAP rating scale outcomes) are disseminated to the team during ward round meetings and case presentations. The importance of this process is highlighted.
		Two		2			
		Three			3		
		Four		2			
		Five			3		
		Six	1				
		Seven		2			
4.7.6	Units contribute to a national dataset to allow for information sharing e.g. QNIC ROM.	One	1			1	Overall, there are very little responses on the satisfaction of this unit standard. From what was said, there is uncertainty to the presence of national quality network datasets to allow for information sharing. Furthermore, such information management will require funding.
		Two	1				
		Three	1				
		Four	1				
		Five	1				
		Six	1				
		Seven		2			

Table 14 Continued

Type 2 Standards for the Care and Treatment (n = 14)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
4.8.2	Staff ask young people for feedback about the food and this is acted upon.	One	1			2	Evidence may be available through kitchen stock/food requisition forms. On occasions, feedback and concerns from the patients are requested. However, there are difficulties in meeting these concerns regarding the food selection and or preference, unless there are serious health related concerns.
		Two		2			
		Three			3		
		Four	1				
		Five			3		
		Six					
		Seven		2			
4.8.3	Where there is a therapeutic benefit staff eat with the young people at mealtimes and the cost of the staff meal is covered by the organisation.	One	1			2	Overall, this tends to only apply to nursing staff who supervise the children daily. According to nursing process notes and clinical notes, there may be therapeutic benefit depending on the specificity of the child's case where there may be clinical indication to do so (e.g., eating disorders).
		Two		2			
		Three		2			
		Four	1				
		Five		2			
		Six					
		Seven		2			
4.8.4	Where there is a therapeutic benefit, there are arrangements for families to eat at mealtimes and the cost of the meal is covered by the organisation. *Guidance: Therapeutic benefits may include working with ED young people, social interaction, normalisation, role-modeling etc.*	One	1			1	Overall, according to limited responses available, this has never really be conducted but there may be a chance it could be arranged, particularly for children with eating disorder based in the family therapeutic programme. These are highly specific cases however.
		Two	1				
		Three	1				
		Four	1				
		Five	1				
		Six	1				
		Seven			3		

Table 14 Continued

Type 2 Standards for the Care and Treatment (n = 14)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
4.9.2	There is a weekly minuted community meeting that is attended by young people and staff members. Guidance: This is an opportunity for young people to share experiences, to highlight issues on the ward/unit and to review the quality and provision of activities with staff members. The meeting should be facilitated by a professional who has an understanding of group dynamics.	One	1			2	Overall, there is contention with the satisfaction of this unit standard. Some responses have pointed out that community meeting and feedback are done daily where it is documented in nursing notes. Some have responded in saying that this is not routinely done and instead takes the shape of worry groups facilitated by nurses where children's experiences and issues can be verbalized.
		Two	1				
		Three		2			
		Four	1				
		Five		2			
		Six			3		
		Seven		2			
4.9.3	Young people have access to relevant faith-specific and/or spiritual support, preferably through someone with an understanding of mental health issues.	One	1			1	Overall, this access is unfortunately not offered at the TLC despite child and parent/carer requests being able to be made along with volunteers based at the main hospital RCWMCH. This usually occurs when children are at home on the weekend or in the holiday programme.
		Two	1				
		Three	1				
		Four	1				
		Five	1				
		Six		2			
		Seven		2			

Of the 14 Type 2 unit standards measured, six (42.86 %) possessed overall modes that indicated that they were not met. A total of five (35.71 %) possessed overall modes that indicated that they were partially met and three (21.43 %) possessed overall modes that indicated that they were fully met. As such, for the Type 2 unit standards, while the majority were found to be not met, the difference between the overall ratings is marginal.

Type 3 Unit Standards: Category 4

Table 15 presents the Type 3 standards of the care and treatment category (n=2).

Table 15
Type 3 Standards for the Care and Treatment (n = 2)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
4.6.9	Educational outings are provided, as appropriate.	One		2		2	Overall, the past number of years have brought with it numerous outings organised for the children admitted but due to recently developed hospital regulations from management, successfully approved outings for the children has been difficult despite the schools willingness to facilitate such an occasion.
		Two		2			
		Three		2			
		Four		2			
		Five		2			
		Six		2			
		Seven	1				
		Eight		2			
		Nine		2			
4.9.7	Young people have access to a specialised pharmacist and/or pharmacy technician to discuss medications.	One	1			2	Overall, any medication matters would be brought up with the medication officer and psychiatrist. Given the age of the children admitted, usually they will not discuss the medication directly where the parents/carers have access to more specialised pharmacy technicians.
		Two		2			
		Three		2			
		Four		2			
		Five		2			
		Six	1				
		Seven			3		

Of the two Type 3 unit standards, both possessed overall modes that indicated they were partially met.

Based on the responses and critique of the unit standards for care and treatment, the evaluator identified which standards were deemed to be the highest met unit standards.

Highest Met Unit Standards of Category 4

The section below illustrates both the highest met unit standards across Category 4. The highest met standards highlighted were determined by the extent to which the standard was collectively rendered fully met by the participants.

4.1.1 (Type 1):

Young people have a risk assessment which is completed using a formal tool and include a comprehensive assessment of: risk to self; risk to others; risk from others.

4.6.2 (Type 2):

The unit provides a broad and balanced curriculum that is suitable and flexible, appropriate to the students' needs.

4.6.11 (Type 1):

When young people are absent without leave, the team (in accordance with local policy): activates a risk management plan; makes efforts to locate the young people; and alerts carers, people at risk and the relevant authorities.

4.9.13 (Type 1):

Young people are treated with compassion, dignity and respect. *Guidance: This includes respect for a young person's race, age, sex, gender reassignment, marital status, sexual orientation, maternity, disability and social background*.

Figure 6. Highest Met Unit Standards of Category 4

Category 5: Information, Consent and Confidentiality

The Information, Consent and Confidentiality Category focuses mainly on the children admitted and their information which would include their parents/carers and how effectively and securely it is stored. It delves into aspects of obtaining consent for treatment and examination. There are a total of 27 unit standards for this category.

Type 1 Unit Standards: Category 5

Table 16 presents the standards of Category 5 (i.e., information, consent and confidentiality at the TLC) that are identified as Type 1 (n=17). The individual responses of the participants can be seen in Appendix G.

Table 16

Type 1 Standards for Information, Consent and Confidentiality (n=17)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
5.2.1	Information, which is accessible and easy to understand, is provided to young people and carers.	One		2		3	Currently, the TLC provides an information pack to parents/carers with a designed section for children. Additional welcome packs are currently in the process of development.
		Two			3		
		Three			3		
		Four			3		
		Five			3		
		Six			3		
		Seven			3		
5.2.2	The young person is given an age appropriate 'welcome pack' or introductory information that contains the following: • A clear description of the aims of the ward/unit; • The current programme and modes of treatment; • The ward/unit team membership; • Personal safety on the ward/unit; • The code of conduct on the ward/unit; • Ward/unit facilities and the layout of the ward/unit; • What practical items can and cannot be brought in; • Resources to meet spiritual, cultural and gender needs	One		2		2	The information pack introduced covers these purposes but does not contain all the information listed. Welcome packs are currently being produced.
		Two		2			
		Three			3		
		Four		2			
		Five		2			
		Six		2			
		Seven		2			

Table 16 Continued

Type 1 Standards for Information, Consent and Confidentiality (n=17)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
5.2.3	The welcome pack should include: The complaints procedure; who else has access to information that the young person shares with the services; circumstances under which information may be disclosed or shared.	One		2		2	Again, not all of this is covered in a welcome pack specifically but the parents are able liaise with a family therapist and psychologist as services to can provide them with the information.
		Two	1				
		Three			3		
		Four		2			
		Five		2			
		Six		2			
		Seven		2			
5.2.5	Young people are given verbal and written information on: • Their rights regarding consent to care and treatment; • How to access advocacy services; • How to access a second opinion; • How to access interpreting services; • How to raise concerns, complaints and compliments; • How to access their own health records	One	1			2	The TLC distributes some of the information. This is predominantly done verbally and not in a written format. New welcome packs will hope to cover this content more extensively.
		Two		2			
		Three			3		
		Four		2			
		Five		2			
		Six		2			
		Seven		2			
5.3.1	Each young person is allocated key worker(s) and the young person and their parents/carers are told who this is.	One		2		3	As standard practice, the children admitted are assigned a special nurse and case manager who satisfy the role of key workers. Not all children are aware of who they have been assigned in the early stages of admission.
		Two			3		
		Three			3		
		Four			3		
		Five			3		
		Six			3		
		Seven			3		

Table 16 Continued

Type 1 Standards for Information, Consent and Confidentiality (n=17)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
5.5.1	Young people and their parents/carers are informed verbally and in writing of their right to confidentiality and its limitations.	One		2		2	Their confidentiality and it limitations are predominantly provided verbally relative to written documentation. This is particular the case where sensitive information is shared.
		Two			3		
		Three			3		
		Four		2			
		Five			3		
		Six		2			
		Seven		2			
5.5.2	Consent is sought prior to the disclosure of case material to parents/carers if the young person is assessed as able to make a decision. *Guidance: In certain circumstances this may be overruled if felt in the young person's best interests. The young person should be informed when this happens.*	One		2		3	Consent from the parents and children, to a certain degree given their age and capacity, is sought by the TLC. Documentation is conducted but more may be required.
		Two			3		
		Three			3		
		Four		2			
		Five		2			
		Six			3		
		Seven			3		
5.5.3	The young person's consent to the sharing of clinical information outside the clinical team is recorded. If this is not obtained the reasons for this are recorded.	One	1			2	Overall, where age appropriate and under certain conditions their consent may be recorded by staff but more documentation recorded is needed.
		Two		2			
		Three			3		
		Four		2			
		Five		2			
		Six	1				
		Seven		2			

Table 16 Continued

Type 1 Standards for Information, Consent and Confidentiality (n=17)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
5.6.1	Consent is sought and recorded by staff. *Guidance: Where the young person is assessed as not having competency to consent then this should also be recorded. This applies to both medication and therapy and should be sought by staff members administering the treatment.*	One	1			1	In the current context, due to the general age of the children admitted and according the Children's Act, this is usually completed through assent of the parents. It is unclear whether competency from the children is not sought.
		Two		2			
		Three			3		
		Four		2			
		Five	1				
		Six	1				
		Seven		2			
5.6.2	All young people's consent is recorded when a decision is required about their care. Where young people are not able to give consent, their views are ascertained as far as possible and taken into account. The legal basis for giving the proposed treatment or intervention is recorded.	One	1			1	Treatment, both therapeutic and medical, is discussed and explained to the children, to a certain extent through assent and not consent from the children.
		Two		2			
		Three			3		
		Four	1				
		Five	1				
		Six	1				
		Seven		2			
5.6.3	Staff informs young people both verbally and in writing of their right to agree to or refuse treatment and the limits of this.	One	1			2	Overall, children admitted are informed about their rights verbally but not in writing.
		Two		2			
		Three			3		
		Four	1				
		Five		2			
		Six		2			
		Seven		2			

Table 16 Continued

Type 1 Standards for Information, Consent and Confidentiality (n=17)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
5.6.4	For all young people, the young person's capacity and/or competency is assessed and recorded when a decision is required about their care.	One	1			3	There is contention as to whether competency as per its definition of the children is conducted. They are assessed as part of psychiatric and psychological assessment which may inform the level of the child's participation in any decision making.
		Two	1				
		Three			3		
		Four			3		
		Five	1				
		Six			3		
		Seven			3		
5.6.5	Where young people are not able to give consent, their views are ascertained as far as possible and taken into account, and the legal basis for giving the proposed treatment or intervention is recorded.	One	1			3	This has been illustrated according to previous responses related to the children's capacity to consent.
		Two			3		
		Three			3		
		Four			3		
		Five	1				
		Six			3		
		Seven		2			
5.6.7	Parental responsibility is recorded in the young person's notes.	One			3	3	This is routinely done as standard practice at the TLC most notably from the social work department.
		Two			3		
		Three			3		
		Four			3		
		Five			3		
		Six			3		
		Seven			3		

Table 16 Continued

Type 1 Standards for Information, Consent and Confidentiality (n=17)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
5.6.8	Young people and carers are offered written and verbal information about the young person's mental illness. Guidance: Verbal information could be provided in a 1:1 meeting with a staff member, a ward round or in a psycho-education group.	One	1			3	Overall, it is predominantly the parents/carers who are informed both verbally and on written documentation of the details of the child's mental illness and diagnoses. More participation of the child is need appropriately.
		Two			3		
		Three			3		
		Four		2			
		Five			3		
		Six		2			
		Seven			3		
5.6.9	Young people have an assessment of their capacity to consent to admission, care and treatment within 24 hours of admission.	One	1			1	Due to their age level of appropriateness, children under 12 years of age in the TLC are made aware through parental assent and not consent.
		Two			3		
		Three			3		
		Four	1				
		Five	1				
		Six		2			
		Seven			3		
5.6.10	The team follows a protocol for responding to carers when the young person does not consent to their involvement.	One	1			1	Currently, this protocol is discussed prior to admission but no written policy is in place it seems.
		Two		2			
		Three			3		
		Four	1				
		Five	1				
		Six		2			
		Seven			3		

Of the 17 Type 1 unit standards measured, four (23.53 %) possessed overall modes that indicated that they were not met. A total of six (35.29 %) possessed overall modes that indicated that they were partially met and a total of seven (41.18 %) possessed overall modes that indicated that they were fully met. As such, for the Type 1 unit standards, the majority of standards were found to be fully met by the respective participants despite the narrow margins between all three scales.

Type 2 Unit Standards: Category 5

Table 17 presents the Type 2 standards of the information, consent and confidentiality category (n=9).

Table 17
Type 2 Standards for Information, Consent and Confidentiality (n=9)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
5.1.1	Clear information is made available, in paper and/or electronic format, to young people, carers and healthcare practitioners on: • A simple description of the ward/unit and its purpose; • Admission criteria; • Clinical pathways describing access and discharge; • Main interventions and treatments available; • Contact details for the ward/unit and hospital.	One		2		3	Overall, this is routinely conducted at the TLC as part of the preadmission information packs and TLC ward programmes. It is slightly unclear whether all the information listed is provided.
		Two			3		
		Three			3		
		Four		2			
		Five			3		
		Six			3		
		Seven			3		
5.1.2	The service has a website which provides information about the unit that young people and parents/carers can access prior to admission.	One	1			1	The RCWMCH and UCT contain websites with very limited information on the TLC. Furthermore, the Division of Child and Adolescent Psychiatry (DCAP) contain electronic brochures but there is no dedicated site to the TLC.
		Two		2			
		Three	1				
		Four	1				
		Five	1				
		Six			3		
		Seven		2			
5.2.4	Staff members explain the main points of the welcome pack to the young person and ask if they need further information on anything explained.	One		2		2	The children admitted are provided with limited orientation and explanation as most of the information is provided to the parents/carers.
		Two		2			
		Three			3		
		Four		2			
		Five	1				
		Six		2			
		Seven		2			

Table 17 Continued

Type 2 Standards for Information, Consent and Confidentiality (n=9)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
5.2.6	The team provides each carer with a carer's information pack. *Guidance: This may include the names and contact details of key staff members on the unit. It also includes other local sources of advice and support such as local carers' groups, carers' workshops and relevant charities.*	One		2		3	During initial assessment phases this information is handed over to the parents/carers but not all information is covered.
		Two	1				
		Three			3		
		Four		2			
		Five			3		
		Six			3		
		Seven		2			
5.3.2	Staff updates parents/carers on their child's progress at a minimum of once a week, subject to confidentiality.	One		2		2	Overall, parents/carers do receive regular updates and feedbacks from case managers and nursing staff, particularly during visiting hours on Wednesdays. It is however not conducted to a full and consistent extent as suggested.
		Two		2			
		Three			3		
		Four		2			
		Five			3		
		Six		2			
		Seven			3		
5.4.1	Staff members wear their Trust/ Organisation ID when working on the ward and this is easily visible.	One		2		2	The main hospital RCWMCH does have name badges issued but staff members do not consistently wear them as examined through personal observation.
		Two		2			
		Three			3		
		Four		2			
		Five		2			
		Six		2			
		Seven			3		

Table 17 Continued

Type 2 Standards for Information, Consent and Confidentiality (n=9)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
5.4.2	There is a board on display with the names and photographs of staff.	One	1			2	The previous which displayed names and photographs was present but broken and is subsequently being updated.
		Two		2			
		Three		2			
		Four		2			
		Five		2			
		Six		2			
		Seven		2			
5.6.6	Assessments of young people' capacity (and competency for young people under the age of 16) to consent to care and treatment in hospital are performed in accordance with current legislation and documented in the young people' notes. When young people do not have capacity to consent, best interest processes involving professionals and family (where appropriate) are followed.	One	1			3	In the current context, due to the general age of the children admitted and according the Children's Act, this is usually completed through assent of the parents. It is unclear whether competency from the children is not sought.
		Two			3		
		Three			3		
		Four		2			
		Five			3		
		Six			3		
		Seven			3		
5.6.6*	Written information is given to parents/carers which contains information about consent and their rights, and the limitations of these.	One	1			2	Overall, written information in the information is limited. This is mainly applicable to when parents/carers do not provide consent in which they are informed of their rights and consent and the applicable limitations of these which is usually provided verbally.
		Two		2			
		Three		2			
		Four		2			
		Five		2			
		Six			3		
		Seven		2			

Note. The unit standards that are marked with an * are duplicate standards from the updated and revised standards post the 2016 reviews. These revisions are either based on the type status or simply new unit standards that have been added to the overall checklist with the same unit standard number.

Of the nine Type 2 unit standards measured, one (11.11 %) possessed an overall mode that indicated that it was not met. A total of five (55.56 %) possessed overall modes that indicated that they were partially met and three (33.33 %) possessed overall modes that indicated that they were fully met. As such, for the Type 2 unit standards, the majority of standards were found to be partially met by the respective participants despite the narrow margins between all three scales.

Type 3 Unit Standards: Category 5

Table 18 presents the Type 3 standards of the information, consent and confidentiality category (n=1).

Table 18
Type 3 Standards for Information, Consent and Confidentiality (n=1)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
5.2.7	There is evidence that information leaflets for parents/carers and young people have had involvement from parents/carers or young people in developing them.	One	1			1	There is no evidence of specific information leaflets. In the preadmission pack, however, there may have been indicated of parents/carers and patients input but more refining and revisions are needed.
		Two		2			
		Three		2			
		Four	1				
		Five	1				
		Six	1				
		Seven	1				

The Type 3 unit standard listed for category 3 was deemed not met based on the overall mode.

Based on the responses and critique of the unit standards for information, consent and confidentiality, the evaluator identified which standards were deemed to be the highest met unit standards.

Highest Met Unit Standards of Category 5

The section usually illustrates both the highest met unit standards across a category. The highest met standards are determined by the extent to which the standard was collectively rendered fully met by the participants. Overall, none of the unit standards for category 5 were deemed fully met by all participants who responded to the questionnaire.

Category 6: Young People's Rights and Safeguarding Children

The Young People's Rights and Safeguarding Children Category focuses on the legal and regulated framework in which multidisciplinary team members operate given the age of children admitted to the unit. Furthermore, the rights and dignity of the children and their parents/carers are addressed in this category. There are a total of 27 unit standards for this category.

Type 1 Unit Standards: Category 6

Table 19 presents the standards of Category 6 (i.e., young people's rights and safeguarding children at the TLC) that are identified as Type 1 (n=25). The individual responses of each participant can be seen in Appendix H.

Table 19

Type 1 Standards for Young Peoples' Rights and Safeguarding Children (n=25)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
6.1.4	Staff explains to the young person who their Nearest Relative/Named Person is and why this is relevant.	One			3	3	Generally, children admitted into the TLC are aware of this given their admission with parents/carers and designated social services in support.
		Two			3		
		Three			3		
		Four			3		
		Five			3		
		Six			3		
		Seven			3		
6.1.5	The young person's Nearest Relative/Named Person is recorded in the young person's notes.	One	1			3	As standard practice, the details of the children's parents/carers are included in patient filing, which is usually collected during initial interviewing.
		Two		2			
		Three		2			
		Four			3		
		Five			3		
		Six			3		
		Seven			3		
6.1.6	Information is given to the Nearest Relative/Named Person about their rights.	One			3	3	According to the feedback provided, information is provided to the Nearest Relative/Named Person routinely.
		Two		2			
		Three			3		
		Four			3		
		Five			3		
		Six			3		
		Seven			3		

Table 19 Continued

Type 1 Standards for Young Peoples' Rights and Safeguarding Children (n=25)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
6.2.1	Young people are able to see a clinician on their own, although this may be refused in certain circumstances and the reasons why are explained.	One			3	3	According to clinical and nursing notes, children have access to a senior registrar on a daily basis.
		Two			3		
		Three			3		
		Four	1				
		Five			3		
		Six			3		
		Seven			3		
6.2.2	Young people are asked for their preference of staff member to act as a chaperone for physical examinations. This is provided if feasible and if not the reasons for this are documented.	One	1			2	Overall, this process is applied to a certain degree. The admitted child's interests are taken into consideration regarding preference and comfort of those present. It becomes difficult due to staff roster schedules where a preferred staff member may not be on duty.
		Two		2			
		Three			3		
		Four			3		
		Five			3		
		Six	1				
		Seven			3		
6.2.2*	Staff members are able to access training or specific information about the mental health needs of young people from minority or hard-to-reach groups. This may include: • Black, Asian and minority ethnic groups; • Asylum seekers or refugees; • Lesbian, gay, bisexual or transgender people; • Travellers.	One	1			2	Overall, training within this area is available for access but its unfortunately limited and not always accessible to all staff. Information tends to be accessed on an individual basis.
		Two		2			
		Three		2			
		Four		2			
		Five					
		Six		2			
		Seven			3		

Table 19 Continued

Type 1 Standards for Young Peoples' Rights and Safeguarding Children (n=25)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
6.2.3	The unit has procedures to ensure that young people's access to media (e.g. TV, DVDs, audio and the internet) is age appropriate.	One	1			3	Overall, this is facilitated and supervised according to the therapeutic programme established. Despite little to no access to the internet, all other materials are made available with strict supervision.
		Two		2			
		Three			3		
		Four			3		
		Five			3		
		Six			3		
		Seven			3		
6.3.1	Information provided on complaints assures young people and parents/carers that if they complain they will not be discriminated against and their care will not be compromised.	One			3	3	There is some contention with this standards satisfaction. Some team members agree that a complaints and compliments policy and quality assurance policy is in place whilst others do not. Some are aware that parents/carers are informed of non-discrimination for complaints.
		Two			3		
		Three			3		
		Four			3		
		Five			3		
		Six			3		
		Seven			3		
6.4.1	The team effectively manages young people violence and aggression.	One		2		3	As standard practice, this management is carried out by staff members, especially from the practical support provided by behavioural training offered by the TLC and Timian. However, in reality it is difficult especially with inexperienced staff who may use Time Out procedures more frequently and when not necessary.
		Two		2			
		Three			3		
		Four		2			
		Five			3		
		Six			3		
		Seven			3		

Table 19 Continued

Type 1 Standards for Young Peoples' Rights and Safeguarding Children (n=25)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
6.4.1*	Young people who are involved in episodes of restrictive physical intervention, or compulsory treatment including tranquilisation, have their vital signs monitored by nursing staff in collaboration with medics and any deterioration is responded to.	One		2		3	There is some uncertainty with the application of this procedure as some feedback suggests unawareness. According to nursing and clinical notes and vital sign charts, observations are conducted daily by staff members who engage with restrictive intervention.
		Two		2			
		Three			3		
		Four			3		
		Five			3		
		Six	1				
		Seven			3		
6.4.1*	Staffs know how to prevent and respond to sexual exploitation, coercion, intimidation and abuse on the ward. *Guidance: Staff must consider whether sexual incidents that are said to be consensual have been the result of coercion, exploitation or where a person's capacity to consent may have been affected by her mental health. Where there is any doubt, the incident must be investigated.*	One	1			3	Overall, these incidents may be more appropriate to adolescent units/wards, however, if such instances occur, it is subsequently attended to by the team where incident reports are completed thereafter. The parents of the child involved are made aware of this.
		Two					
		Three		2			
		Four	1				
		Five			3		
		Six			3		
		Seven			3		
6.4.3	After any episode of control and restraint, or compulsory treatment including rapid tranquillisation, the team makes sure that other young people on the ward/unit who are distressed by these events are offered support and time to discuss their experiences.	One		2		3	Overall, as standard practice, the staff of the TLC run 'worry groups' to provide a safe and secure space of support for the children to discuss what had incurred and how they managed what they were feeling. Again, this is dependent on the level of experience of the staff members.
		Two		2			
		Three			3		
		Four			3		
		Five			3		
		Six	1				
		Seven			3		

Table 19 Continued

Type 1 Standards for Young Peoples' Rights and Safeguarding Children (n=25)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
6.4.4	Parents/carers are informed about all episodes of restraint within 24 hours. If for any reason this does not occur, reasons are documented in the young person's notes.	One	1			1	Overall, restraint as defined here is rarely utilised by staff members as opposed to escorting the child to Time Out. Depending on the severity and consistency of the behaviour, parents/carers may be informed but usually not within 24 hours.
		Two	1				
		Three			3		
		Four	1				
		Five			3		
		Six	1				
		Seven			3		
6.4.4*	Individualised support plans, incorporating behaviour support plans, are implemented for all young people who are being managed through the repeated use of restrictive physical interventions. *Guidance: The support plans are developed using functional analyses/applied behaviour analyses to understand, manage and prevent incidents.*	One		2		2	Overall, according to nursing and clinical notes and staff weekly meeting schedules, detailed behavioural plans are developed occasionally but not routinely. It's important to try and individualise plans and goals for each child admitted to the TLC
		Two		2			
		Three			3		
		Four		2			
		Five			3		
		Six	1				
		Seven			3		
6.4.4*	Systems are in place to enable staff members to quickly and effectively report incidents. Managers encourage staff members to do this.	One		2		3	Overall, systems of effectively reporting incidents from staff members are established at the TLC which is discussed thoroughly in team meetings such as operational management meeting. More encouragement is needed for staff members to learn from these incidents and reports as supposed to means of practice
		Two			3		
		Three			3		
		Four			3		
		Five			3		
		Six			3		
		Seven			3		

Table 19 Continued

Type 1 Standards for Young Peoples' Rights and Safeguarding Children (n=25)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
6.4.5	The team audits the use of restrictive practice, including face-down restraint.	One	1			1	Overall, audits are conducted on Time Out procedures and not restrictive practice as outlined in this unit standard.
		Two	1				
		Three		2			
		Four	1				
		Five			3		
		Six	1				
		Seven		2			
6.4.6	Staff members know how often young people are restrained and how this compares to benchmarks, e.g. by participating in multi-centre audits or by referring to their previous years' data.	One	1			1	Overall, no audits or comparisons are conducted with other units on restraint statistics. Staff members, however, reportedly know how often children admitted are restrained.
		Two	1				
		Three			3		
		Four	1				
		Five	1				
		Six	1				
		Seven		2			
6.4.7	The unit follows organisational policies for untoward occurrences and critical incident reporting. *Guidance: This includes the circumstances and justification of using restraint, and the recording of information after a restraint has occurred.*	One		2		3	Overall, this policies and procedures are followed through behaviour management policy and incident reporting. However, more reflective practice is recommended.
		Two			3		
		Three			3		
		Four		2			
		Five		2			
		Six			3		
		Seven			3		

Table 19 Continued

Type 1 Standards for Young Peoples' Rights and Safeguarding Children (n=25)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
6.5.1	It is recorded as to whether or not a young person has a child protection plan in place.	One		2		3	Overall, there were little detailed responses to this unit standard specifically. From the feedback there was an understanding that this plan is carried out through the social work department but there is uncertainty to what the local equivalent would be.
		Two			3		
		Three			3		
		Four		2			
		Five			3		
		Six			3		
		Seven			3		
6.5.2	The unit has a named child protection lead and staff knows who this is.	One	1			1	Overall, there were little detailed responses to this unit standard specifically. One point refers to the social worker who takes up this role of child protection lead whilst the other point disagrees with a position being available in the first place.
		Two	1				
		Three			3		
		Four	1				
		Five					
		Six			3		
		Seven			3		
6.5.3	The unit has policies and procedures which are compatible with LSCB (or local equivalent) guidelines, including the conduct of reviews and procedures for working together.	One	1			1	No responses were provided on this unit standard.
		Two					
		Three		2			
		Four		2			
		Five	1				
		Six			3		
		Seven					

Table 19 Continued

Type 1 Standards for Young Peoples' Rights and Safeguarding Children (n=25)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
6.5.4	Staff knows what to do if there are safeguarding concerns and who to contact, during and out of working hours.	One	1			3	The TLC staff are aware of these procedures through the RCWMCH social work department standard operating procedures and Department of Social Development.
		Two			3		
		Three			3		
		Four			3		
		Five					
		Six			3		
		Seven			3		
6.5.5	If a young person raises safeguarding concerns or someone else raises concerns about them, staff inform them of the process that will be followed by the unit and other agencies.	One	1			3	Overall, there were little detailed responses to this unit standard specifically. According to feedback given, this process is reported to the social work department as standard practice.
		Two		2			
		Three			3		
		Four		2			
		Five	1				
		Six			3		
		Seven			3		
6.6.1	The local authority will be made aware if a young person remains on the unit for a consecutive period of 3 months (in line with section 85 of the Children Act 1989).	One	1			2	Overall, the majority of responses have said that this aspect is irrelevant to the TLC and is not carried out. Another response refers the reader to this process being carried out by the social work.
		Two					
		Three			3		
		Four		2			
		Five					
		Six		2			
		Seven			3		

Table 19 Continued

Type 1 Standards for Young Peoples' Rights and Safeguarding Children (n=25)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
6.6.2	The local authority is alerted if the whereabouts of the person with parental responsibility is not known or if that person has not contacted the young person.	One		2		3	Under this conditions, which are apparently rare, the TLC will ensure that the Department of Social Development are contacted.
		Two			3		
		Three			3		
		Four			3		
		Five			3		
		Six			3		
		Seven			3		

Note. The unit standards that are marked with an * are duplicate standards from the updated and revised standards post the 2016 reviews. These revisions are either based on the type status or simply new unit standards that have been added to the overall checklist with the same unit standard number.

Of the 25 Type 1 unit standards measured, five (20 %) possessed overall modes that indicated that they were not met. Four (16 %) possessed overall modes that indicated that they were partially met and a total of 16 (64 %) possessed overall modes that indicated that they were fully met. As such, for the Type 1 unit standards, the majority of standards were found to be fully met by the respective participants. The margin between those deemed fully met relative to those deemed partially or not met is noticeably large. There were more unit standards deemed not met than partially met.

Type 2 Unit Standards: Category 6

Table 20 presents the Type 2 standard of the young people's rights and safeguarding children category (n=1).

Table 20
Type 2 Standards for Young Peoples' Rights and Safeguarding Children (n=1)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
6.4.2	After any episode of control and restraint, or compulsory treatment including rapid tranquillisation, the team spends time with the young person reflecting on why this was necessary. The young person's views are sought and they are offered the opportunity to document this in their care record along with any disagreement with healthcare professionals.	One		2		2	Overall, this would be conducted according to TLC Behaviour management as standard practice and recorded in nursing and clinical notes. This is completed to some degree where there may often not be space and/or time for key reflection. This procedure may also be carried out by inexperienced staff members
		Two		2			
		Three			3		
		Four		2			
		Five		2			
		Six	1				
		Seven			3		

Of the one Type 2 unit standard measured, the overall mode indicated that it was partially met.

Type 3 Unit Standards: Category 6

Table 21 presents the Type 3 standard of the young people's rights and safeguarding children category (n=1).

Table 21
Type 3 Standards for Young Peoples' Rights and Safeguarding Children (n=1)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
6.2.2	The ward has a designated equality champion.	One	1			1	There is very little response to this unit standard. Overall, the is argument for equity training to be offered but no designated equality champion is available. The roles may be taken on by operational management,.
		Two	1				
		Three	1				
		Four	1				
		Five	1				
		Six		2			
		Seven			3		

Of the one Type 3 unit standard measured, the overall mode indicated that it was not met. Based on the responses and critique of the unit standards for young people's rights and safeguarding children, the evaluator identified which standards were deemed to be the highest met unit standards.

6.1.4 (Type 1):

Staff explains to the young person who their Nearest Relative/Named Person is and why this is relevant.

6.1.6 (Type 1):

Information is given to the Nearest Relative/Named Person about their rights.

6.2.1 (Type 1):

Young people are able to see a clinician on their own, although this may be refused in certain circumstances and the reasons why are explained.

6.3.1 (Type 1):

Information provided on complaints assures young people and parents/carers that if they complain they will not be discriminated against and their care will not be compromised.

Figure 7. Highest Met Unit Standards for Category 6.

Category 7: Clinical Governance

The Clinical Governance Category ultimately focuses on core policies and protocols in the place of inpatient psychiatric units which cover a variety of ethical, social and health-related

matters for the children admitted and their respective parents/carers. There are a total of 37 unit standards for this category.

Type 1 Unit Standards: Category 7

Table 22 presents the standards of Category 7 (i.e., clinical governance at the TLC) that are identified as Type 1 (n=26). The individual responses of each participant can be seen in Appendix I.

Table 22
Type 1 Standards for the Clinical Governance (n = 26)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
7.1.1	Young people and their carers are given the opportunity to feedback about their experiences of using the service, and their feedback is used to improve the service.	One	1			2	Overall, this process is more informally conducted where verbal feedback may be received in discharge meetings from the parents/carers and written feedback in the form of complaints and compliments for submission. Specific experience forms are not available at the TLC.
		Two		2			
		Three		2			
		Four		2			
		Five		2			
		Six			3		
		Seven		2			
7.2.2	There are dedicated resources, including protected staff time to support clinical audit within the directorate or specialist areas.	One	1			2	Overall, peer audits and national core standard audits are conducted annually by the hospital.
		Two		2			
		Three		2			
		Four		2			
		Five		2			
		Six	1				
		Seven			3		
7.3.1	The lead clinician for the service has operational responsibility to ensure that identified risks are acted upon.	One		2		3	Overall, risks are identified and discussed with operational managers, hospital managers and DCAP Head in admin and crisis management meetings. The TLC places a time frame on seeing to the aspects of risk to provide solutions to reduce it accordingly. This can be difficult when it comes to security and/or inexperienced staff.
		Two			3		
		Three			3		
		Four			3		
		Five			3		
		Six		2			
		Seven			3		

Table 22 Continued

Type 1 Standards for the Clinical Governance (n = 26)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
7.3.2	The organisation has a risk management strategy.	One	1			3	Overall, there are various platforms that allow for risk management strategies to be carried out, such as DCAP management of psychiatric and medical emergency policies and CCTV policy to name a few. They are often being updated but carried out weekly to evaluate the situation.
		Two			3		
		Three			3		
		Four			3		
		Five			3		
		Six			3		
		Seven			3		
7.3.3	Staff members share information about any serious untoward incidents involving a young person with the young person themselves and their carer, in line with the Duty of Candour agreement.	One		2		3	Overall, the sharing of the information is dependent on the incident at hand which may be disseminated in adverse incident forms and ward round meetings to name a few. The child is reminded to adhere to safety regulations.
		Two		2			
		Three			3		
		Four		2			
		Five			3		
		Six			3		
		Seven			3		
7.3.4	Lessons learned from incidents are shared with the team and disseminated to the wider organisation.	One		2		3	Overall, throughout the various meetings held with the broader team, information is shared to a certain extent where improvement is needed. More attention is needed on time for reflection.
		Two		2			
		Three			3		
		Four		2			
		Five			3		
		Six			3		
		Seven			3		

Table 22 Continued

Type 1 Standards for the Clinical Governance (n = 26)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
7.4.1	Managers ensure that policies, procedures and guidelines are formatted, disseminated and stored in ways that the team find accessible and easy to use.	One		2		3	Overall, most policies established at the TLC are available and accessible for staff members in files and within the operational manager's office for observation. Its dependent on whether the relevant members choose to observe them.
		Two			3		
		Three			3		
		Four			3		
		Five			3		
		Six			3		
		Seven			3		
7.4.2	There is a written admission procedure, which includes procedures for emergency referrals.	One		2		2	Overall, the admission procedure is carried out as standard practice but there is uncertainty as to the clearly defined written procedure outlined for the TLC multidisciplinary team, especially for the distinction of emergency referrals. Furthermore, rarely are referrals made directly to the TLC.
		Two		2			
		Three		2			
		Four		2			
		Five		2			
		Six			3		
		Seven			3		
7.4.3	The team follows a protocol to manage informal young people who discharge themselves against medical advice. This includes: • Recording the young person's capacity to understand the risks of self-discharge; • Putting a crisis plan in place; • Contacting relevant agencies to notify them of the discharge.	One	1			1	Overall, this is not applicable to the TLC unit as the children are not at an appropriate age to carry out self-discharge from admission.
		Two	1				
		Three	1				
		Four	1				
		Five	1				
		Six	1				
		Seven	1				

Table 22 Continued

Type 1 Standards for the Clinical Governance (n = 26)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
7.4.4	There are policies and procedures on the management of aggression and violence and the use of physical restraint.	One	1			3	Overall, despite contention and little response to summarise, there appears to be such a policy in the form of SOP on management of aggression and violence and the use of physical restraint. Physical restraint is not used regularly.
		Two			3		
		Three			3		
		Four			3		
		Five					
		Six			3		
		Seven			3		
7.4.5	There is an organisational policy for the use of rapid tranquilisation.	One		2		2	Overall, a written policy is in place referred to as the TLC Chemical restraint policy.
		Two		2			
		Three		2			
		Four		2			
		Five					
		Six			3		
		Seven			3		
7.4.6	There is a policy on clinical risk assessment and management.	One	1			3	Overall, there is some uncertainty as to how clear the policies that are present are. Clinical risk assessment and management is performed however accordingly.
		Two	1				
		Three		2			
		Four		2			
		Five			3		
		Six			3		
		Seven			3		

Table 22 Continued

Type 1 Standards for the Clinical Governance (n = 26)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
7.4.7	There is a policy for responding to serious incidents requiring investigation.	One		2		3	Overall, incident reporting is available at the TLC. The Social Work Department would be primarily responsible for leading solutions to such situations.
		Two			3		
		Three		2			
		Four			3		
		Five			3		
		Six			3		
		Seven			3		
7.4.8	The unit has policy and procedures for the management of bullies and for those who have been bullied, which covers both staff and young people.	One	1			2	Overall, there does not appear to be any formally written policies on dealing with bullying in this context as most of it is dealt with informally and within a group facilitated context.
		Two		2			
		Three		2			
		Four		2			
		Five			3		
		Six	1				
		Seven			3		
7.4.9	There is a locked door policy which allows young people to be cared for in the least restrictive environment possible.	One		2		2	Overall, the policy of a least restrictive is reinforced throughout but a locked door policy extending throughout the unit is not fully applied.
		Two		2			
		Three		2			
		Four		2			
		Five			3		
		Six			3		
		Seven			3		

Table 22 Continued

Type 1 Standards for the Clinical Governance (n = 26)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
7.4.10	There are appropriate procedures where units close at weekends.	One		2		3	As standard practice, children admitted would go the main hospital RCWMCH in case of emergencies where their respective parents/carer will be notified. They will be attended to by senior registrars on call and may be sent home depending on the condition.
		Two			3		
		Three			3		
		Four		2			
		Five			3		
		Six			3		
		Seven			3		
7.4.12	There is a policy on the use of mobile phones, including use of camera phones and internet enabled phones.	One	1			3	Overall, there were very little responses. There is uncertainty regarding a written policy but protocols are understood by all children admitted and their parents/carers.
		Two			3		
		Three			3		
		Four			3		
		Five	1				
		Six			3		
		Seven			3		
7.4.13	There is a policy on the use of the internet by young people on the unit.	One	1			1	Overall, there is no internet access to provide to the children admitted. Irrespective of this, they would not be permitted to within the unit itself given their clinical conditions and developmental stage.
		Two	1				
		Three			3		
		Four	1				
		Five	1				
		Six	1				
		Seven	1				

Table 22 Continued

Type 1 Standards for the Clinical Governance (n = 26)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
7.4.14	There is a policy on the use of drugs and alcohol, and on the management of young people who may be abusing drugs and alcohol.	One	1			1	Overall, there are Western Cape Department of Health guidelines on management of patients with substance abuse but no clear policy on these cases specifically is present. It would not be given the developmental stage of the children.
		Two	1				
		Three			3		
		Four	1				
		Five			3		
		Six	1				
		Seven			3		
7.4.15	Staff members follow a protocol when conducting searches of young people and their personal property and visitors where necessary.	One	1			3	Overall, staff members, particularly nurses, routinely check the children's and visitor's property ethically for any dangerous and risk items, such as weapons, where anything brought by the parents/carers is handed over to the staff members.
		Two			3		
		Three			3		
		Four			3		
		Five			3		
		Six		2			
		Seven			3		
7.4.16	The unit has a policy on the use of seclusion. *Guidance: If seclusion is not used, this policy should include how situations are managed when seclusion is needed.*	One		2		3	Within the context of the TLC, this policy and procedure would be referred to the Time Out policy previously discussed which is clearly documented and outlined for staff members.
		Two			3		
		Three			3		
		Four		2			
		Five			3		
		Six			3		
		Seven			3		

Table 22 Continued

Type 1 Standards for the Clinical Governance (n = 26)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
7.4.17	Staff members follow a lone working policy and feel safe when escorting young people on leave.	One	1			1	Overall, there is no clear policy on lone working. Furthermore, nurses do not escort children admitted when on leave, they are fetched directly from their parents/carers from the unit.
		Two					
		Three		2			
		Four	1				
		Five	1				
		Six		2			
		Seven					
7.4.18	The team follows a protocol for managing situations where young people are absent without leave.	One	1			2	Overall, the responses did not detail the specifics of protocol in which children admitted are absent without leave. It is unclear whether this protocol is written down but they are carried accordingly.
		Two		2			
		Three			3		
		Four		2			
		Five		2			
		Six		2			
		Seven			3		
7.4.19	The team understands and follows an agreed protocol for the management of an acute physical health emergency. *Guidance: This includes guidance about when to call 999 and when to contact the duty doctor.*	One		2		3	Overall, this is issued as standard practice according to the management of medical emergency policy. Staff members are aware of the procedures to carry out, especially with the support of the senior registrar or medical doctor on call. Emergency numbers are also made available.
		Two			3		
		Three			3		
		Four			3		
		Five			3		
		Six			3		
		Seven			3		

Table 22 Continued

Type 1 Standards for the Clinical Governance (n = 26)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
7.4.20	The team follows an agreed protocol with local police, which ensures effective liaison on incidents of criminal activity/harassment/violence.	One	1			3	Overall, based on experiences and agreed protocol (which is contended by responses made my TLC members), hospital security and local police are liaised with which is made available with contact details provided.
		Two		2			
		Three			3		
		Four		2			
		Five			3		
		Six			3		
		Seven			3		
7.5.1	The ward/unit is explicitly commissioned or contracted against agreed ward/unit standards.	One	1			3	Very little responses were provided, of which stipulated uncertainty of this contract. One team member referred to the unit being under the Western Cape Department of Health, functioning as designated by province.
		Two					
		Three			3		
		Four	1				
		Five					
		Six			3		
		Seven			3		

Of the 26 Type 1 unit standards measured, four (15.38 %) possessed overall modes that indicated that they were not met. Seven (26.92 %) possessed overall modes that indicated that they were partially met and a total of 15 (57.70 %) possessed overall modes that indicated that they were fully met. As such, for the Type 1 unit standards, the majority of standards were found to be fully met by the respective participants. The margin between those deemed fully met relative to those deemed partially or not met is notable. There were more unit standards deemed partially met than not met despite the narrow margins between the scales.

Type 2 Unit Standards: Category 7

Table 23 presents the Type 2 standards of the clinical governance category (n=6).

Table 23
Type 2 Standards for the Clinical Governance (n = 6)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
7.1.2	Key clinical/service measures and reports are shared between the team and organisation's board, e.g. Findings from serious incident investigations and examples of innovative practice.	One	1			3	Overall, as standard practice, these are shared in regularly ward round and admin meetings with the team.
		Two		2			
		Three			3		
		Four	1				
		Five			3		
		Six		2			
		Seven			3		
7.2.4	Measures are in place to record and audit referrals, terminated referrals and waiting lists.	One		2		3	Overall, the head of the unit keeps the referrals which are based in DCAP referral file and TLC referral file and waiting list.
		Two			3		
		Three			3		
		Four		2			.
		Five		2			
		Six			3		
		Seven			3		
7.2.5	When staff members undertake audits they; • Agree and implement action plans in response to audit reports; • Disseminate information (audit findings, action plan); • Complete the audit cycle.	One	1			2	There were only two responses. One said that clinical audits are not completed. The second referred to National core standards reports which are discussed amongst team members where action plans are agreed upon.
		Two		2			
		Three			3		
		Four		2			
		Five		2			
		Six	1				
		Seven			3		

Table 23 Continued

Type 2 Standards for the Clinical Governance (n = 6)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
7.4.11	There is a clear policy on young people's smoking.	One	1			1	Overall, there is a smoking policy that applies to all (staff and children admitted) through under 12yrs smoking policy on hospital grounds. However, this may not be specifically applicable to the children given their age hence why most responses were deemed not met.
		Two			3		
		Three			3		
		Four		2			
		Five	1				
		Six	1				
		Seven	1				
7.5.5	Key information generated from service evaluations and key measure summary reports (e.g. reports on length of stay) are disseminated in a form that is accessible to all.	One	1			3	Overall, the TLC receives some summary reports from annual reviews and clinicom statistics for supplement as the general responses outline. Progress on the children admitted is written accordingly.
		Two		2			
		Three			3		
		Four			3		
		Five			3		
		Six	1				
		Seven			3		
7.5.6	Young person representatives attend and contribute to local and service level meetings and committees.	One	1			1	This is not conducted the children admitted to the TLC as it is generally not applicable given their age as a minor.
		Two	1				
		Three	1				
		Four	1				
		Five	1				
		Six	1				
		Seven	1				

Of the six Type 2 unit standards measured, two (33.33 %) possessed overall modes that indicated that they were not met. One (16.67 %) possessed an overall mode that indicated that it was partially met and a total of three (50 %) possessed overall modes that indicated that they were fully met. As such, for the Type 2 unit standards, the margin between the unit standards deemed as not met, partially met and fully met was small.

Type 3 Unit Standards: Category 7

Table 24 presents the Type 3 standards of the clinical governance category (n=5).

Table 24

Type 3 Standards for the Clinical Governance (n = 5)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
7.2.1	A range of local and multi-centre clinical audits is conducted which include the use of evidence based treatments, as a minimum.	One	1			2	There were very little responses to this unit standard. Reportedly, peer audits and national core standards audits in place assess broad aspects which include child and adolescent psychiatry (not specific to the field) and therefore not fully multi-centered.
		Two		2			
		Three			3		
		Four			3		
		Five		2			
		Six		2			
		Seven			3		
7.2.3	The team, young people and carers are involved in identifying priority audit topics in line with national and local priorities and young person feedback.	One	1			1	As communicated, the TLC currently does not have young people and carers involved in identifying priority audit topics. .
		Two	1				
		Three		2			
		Four	1				
		Five	1				
		Six	1				
		Seven	1				
7.5.2	Commissioners and service managers meet at least 6 monthly.	One	1			2	Overall, there is uncertainty surround the specific role of commissioners but relevant meetings are held regularly with management.
		Two			3		
		Three		2			
		Four	1				
		Five					
		Six		2			
		Seven			3		

Table 24 Continued

Type 3 Standards for the Clinical Governance (n = 5)

#	Unit Standards	Stakeholder	Not Met	Partially Met	Fully Met	Mode	Qualitative reasoning
7.5.3	The team reviews its progress against its own plan/strategy, which includes objectives and deadlines in line with the organisation's strategy.	One		2		3	Overall, this is reported to happen during annual TLC review meetings as standard practice. However, the deadlines and goals are not always specified.
		Two		2			
		Three			3		
		Four		2			
		Five			3		
		Six			3		
		Seven			3		
7.5.4	The ward/unit has a meeting, at least annually, with all stakeholders to consider topics such as referrals, service developments, issues of concern and to re-affirm good practice.	One	1			2	Overall, this is included in review meetings accordingly. However, as noted, not all stakeholders are included in the meetings.
		Two		2			
		Three			3		
		Four		2			
		Five			3		
		Six		2			
		Seven			3		

Of the five Type 3 unit standards measured, one (20 %) possessed an overall mode that indicated that it was not met. A total of three (60 %) possessed overall modes that indicated that they were partially met and one (20 %) possessed an overall mode that indicated that it was fully met. As such, for the Type 3 unit standards, again the margins between the ratings were small.

Based on the responses and critique of the unit standards for clinical governance, the evaluator identified which standards were deemed to be the highest and lowest met unit standards.

Highest Met Unit Standards of Category 7

Category 7 did not possess a unit standard in which all participants agreed that it was fully met in terms of its satisfaction.

Summary of the Results

In order to best to summarise the results provided in this chapter, I displayed the percentages of the number of unit standards deemed not met; partially met; and fully met for each type in respective pie charts below. Figure 8 displays these statistics for all Type 1 unit standards. Figure 9 displays these statistics for all Type 2 unit standards. Finally, Figure 10 displays these statistics for all Type 3 unit standards.

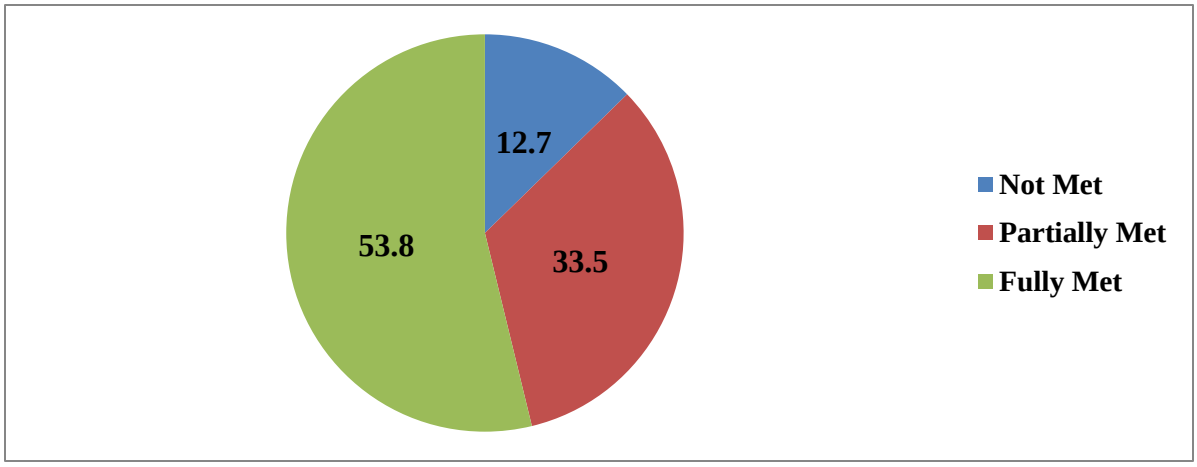


Figure 8. Graphical summary of Type 1 unit standards and their level of compliance with the TLC.

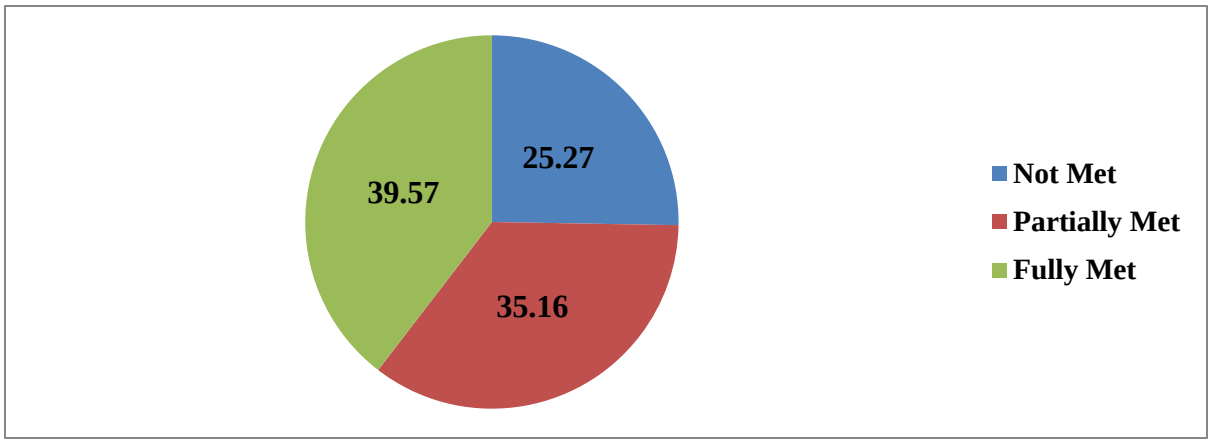


Figure 9. Graphical summary of Type 2 unit standards and their level of compliance with the TLC.

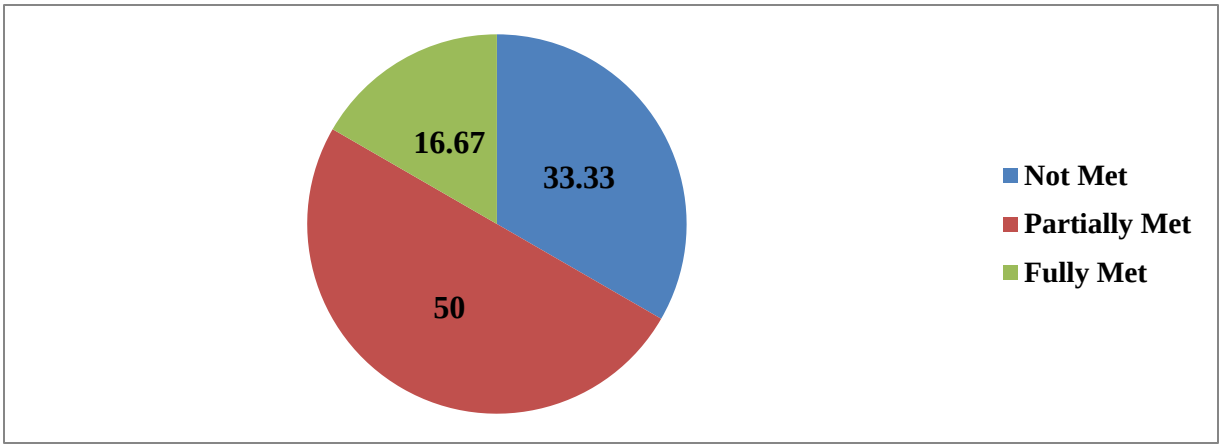


Figure 10. Graphical summary of Type 3 unit standards and their level of compliance with the TLC.

Overall, Figure 8 illustrates to the reader that the majority of Type 1 unit standards measured at the TLC were deemed fully met. However, as explained previously all Type 1 standards would be fully met due to their importance and influence for the successful running of an inpatient unit. So while the majority is met (53.8%) this is low when we consider the crucial factor of these unit standards. Figure 9 illustrates the responses of all Type 2 unit standards with a more balanced outcome yielded by the data providers. Despite the majority of unit standards being deemed fully met, the margins between all three levels of satisfaction are thin. This is an expected result because Type 2 unit standards should be met, but it isn't imperative. So the balance between the overall ratings is in line with Type 2 standards. In contrast, Figure 10 illustrates that the majority of all Type 3 unit standards for the TLC were deemed partially met.

Type 3 unit standards need not be met by an inpatient unit; they are rather nice to have. This is, therefore, a positive result for the TLC.

The summary provided above concludes this results chapter. The next chapter will focus on discussing and unpacking the results provided and to what extent the evaluation questions presented at the end of Chapter One were answered.

Chapter 4: Discussion

The primary aim of this process evaluation was to compare, assess and critique the standards of mental health service and quality of programme implementation of the TLC, as a South African based child inpatient psychiatric unit, against internationally recognised unit standards of service quality. These international unit standards (the Quality Network for Inpatient Child and Adolescent Mental Health Service, QNIC) were derived from child and adolescent psychiatric units based in the United Kingdom (Thompson & Clarke, n.d.). The overall goal of the evaluation was that through the assessment of the unit standards, areas within the TLC's therapeutic milieu environment that may need improvement would be identified.

Overall, the TLC has a good programme design, established in terms of the unit's aims and goals for treatment of the children admitted as inpatients or day-patients. The core activities align to best practice in terms of a therapeutic milieu environment, which as evidenced in Chapter One, has the potential to lead to important outcomes for those children admitted and subsequently discharged. When one investigates the intricate details and mechanisms of the programme, however, many aspects of the unit (identified by the unit standards measured) are indicated to be risks. In other words, they will negatively affect the TLC's fidelity and quality of service. These aspects will be addressed under their respective category in the sections to follow. The evaluation questions posed for each of the seven categories will also be included and answered as part of this discussion chapter.

The TLC's Environment and Facilities

According to the therapeutic milieu environment framework of an optimal healing environment addressed in Chapter One, a unit's environment plays an important role of providing security, safety and comfort for both staff and children admitted into the psychiatric unit (Jonas & Chez, 2004; Tas et al., 2010). In this section, I will illustrate to what extent the TLC's physical and therapeutic milieu environment is being managed and sustained for the children admitted and the staff members. This discussion is ordered by the evaluation questions posed.

Are the premises and the necessary facilities and resources of the TLC inpatient unit designed and managed to ensure that the inpatient or day-patient's rights, privacy, and dignity are respected?

There are a number of unit standards in category one which assess the extent to which an inpatient or day-patient's rights, privacy and dignity are respected. These include the use of mobile phone and internet, access to educational resources and teaching space, the storing of personal information, single and separate bedroom and bathroom usage, respect of personal space by staff, support for chosen faith and disability access. Most of these unit standards are either Type 1- or 2-unit standards. Overall, the majority of the standards pertaining to the TLC's inpatient or day-patient's rights, privacy and dignity were met.

Aspects of the child's rights, privacy and dignity were shown to be respected and managed in the TLC. Children have access to a teaching space (i.e., classroom) where they engage with educational resources and materials for their academic level. Access to bedroom, dining, recreational and bathroom facilities are maintained for the children. They are able to receive visits from family members every Wednesday and on weekends (if they remain in the unit over this time). Furthermore, a child is supported by staff members when they request resources and practice traditions that are specific to their chosen faith and/or belief system.

With regards to electronic equipment (e.g., mobile phones) and access to the internet, children admitted into the TLC are not permitted to access these resources based on their age and the potential risks from usage. This is one of the Type 1 unit standards pertaining to rights, privacy and dignity that were not met by the unit. Internationally access to phones and internet is deemed a right and an essential component to a unit's service delivery. I argue that this is not the case when we take the context of the TLC into account. The TLC caters to inpatients or day-patients who are between the ages of six and twelve. According to Haughton, Aiken, and Cheevers (2015), young children and early teenagers who fall within this age bracket that make regular use of relevant electronic equipment and the internet are associated with experiencing deficits in interpersonal skills, attention and concentration, and physical weight in line with their development. Additionally, within the context of South Africa, access to electronic equipment and the internet is not readily available for the majority of the country's population given their low socioeconomic status (Hoag, Tennen, Stevens, Coman, & Wu, 2016). As such the use of

mobile phones and the internet in South Africa is deemed a luxury and not a right as labelled in the international unit standards.

Another unit standard which the TLC failed to meet fully pertained to the storing of the children's personal information. The TLC does have filing cabinets where the information is kept safely, however, the rooms which house these cabinets are not routinely locked nor does the room have any password or swipe card control. This poses a risk in that staff members, who may not be fully authorised to view a child's personal information, can access these rooms and the cabinets. In these instances, patient confidentiality will be infringed upon as their personal information can be accessed and potentially disseminated to unauthorised individuals (Varcarolis, 2016). It is therefore important that the TLC look into storing information electronically or implementing higher security control over the access to the filing cabinets.

In terms of privacy, results showed that the children's personal space is respected by supervising staff members, particularly during activities that require private space, such as using the bathroom. There is, however, a current lack of single bedrooms available for the children. This was deemed a Type 1 unit standard. For quality inpatient psychiatric units, single bedrooms are expected, but not required according to the international unit standards. The structural layout of the TLC unit has rendered the availability of single bedrooms unattainable. Furthermore, multi-bed rooms, used in the TLC, are conducive for nursing supervision of the children within controlled settings (Jonas & Chez, 2004). While these are legitimate reasons for the lack of individual bedrooms, problems may arise where some children, given the nature of their admission, may require more private spacing due to their clinical need and risk assessment. What this means is that based on risk assessment of the child, he/she may pose potential physical and verbal harm to other children in settings such as in bedrooms (Cabaniss, Cherry, Douglas, & Schwartz, 2016). Therefore, single and separate bedroom settings may help reduce such risk in the unit and benefit the child's need for private spacing (Cabaniss et al., 2016).

With further pertinence to the structural layout of the TLC unit, another Type 1 unit standard addressed whether a disability policy is implemented within the unit. According to the findings, the TLC does have a disability policy, however, access to and within the unit is only partially met. One ramp is in place by the entrance but access inside the unit for disabled individuals is limited (e.g., bathroom usage is not conducive for disabled individuals). The TLC

services are not mandated for patients with physical ailments, but the limited access may impact on those visiting said patients who possess certain disabilities. In emergency situations, such as fires, limited interior access in the unit may put disabled individuals' safety at risk (Jonas & Chez, 2004). Due to the risk of scenarios such as these occurring, plans need to be put in place to structurally increase access in the unit.

Overall, it is evident that the concerns surrounding the privacy, dignity and rights of the children admitted that I have addressed are largely due to constraints of the structural layout of the TLC unit. Despite the management of some resources and parts of the facilities in respecting the privacy, dignity and rights of a child, there are areas, especially the storing of personal information that need more secure management if these rights are to be fully respected.

Does the TLC inpatient unit provide a safe environment for both staff and patients?

Unit standards which assess the extent to which the TLC maintains a safe environment for staff and children admitted include the cleanliness of patient rooms, access to an outdoor space, dining, seclusion, de-escalation and quiet room spacing, secure placement of medication, surveillance and signposting of the facility, lines of sight, auditing of environmental risks, the state of repair and maintenance, the control of heating and ventilation, and the securement of staff and children's property. These unit standards predominantly represent Type 1 or Type 2 standards. Overall, the majority of these standards pertaining to the safety of the environment were deemed to be fully or partially met. However, three areas were indicated as major concerns within this context. I will address these below.

As a least restrictive environment, the TLC does instil a sense of therapeutic milieu and security, and not institutionalisation as general hospitals tend to do. What this means is that the unit itself maintains a unique space and setting for healing relationships and positive interaction to foster between staff members and the children admitted (Mahoney et al., 2009). This process benefits the children by allowing them to see their symptoms, not as problems to deal with, but as goals they that want to achieve (Mahoney et al., 2009).

In terms of the physical environment or surrounding healing space (Jonas & Chez, 2004), however, certain unit standards produce safety concerns for both staff and children at the TLC. The interior of the TLC has been described as being in a state of disrepair due to significant fissures, holes and rotting in the walls and ceilings, which pose risk to natural ramifications (e.g.,

flooding). Furthermore, maintenance staff have not consistently and securely attended to these structural deficits, instead only temporarily resolving them which ultimately maintains that safety risk for the inhabitants. Failure in communication may be a contributor to the lack of resolving these safety concerns (Scholefield, 2008). Given that maintenance staff are external to the TLC and that recent assessments have not been able to reliably communicate the significance of the interior damage, adverse events are at higher risk of occurring (Johnstone, 2007). This is why consistent communication between organisational management and staff members is crucial. If certain areas of the unit continue to pose safety risks for the inhabitants, all operations may consequently be halted (Kanerva, Lammintakanen, & Kivinen, 2013).

In addition to the above structural deficits, limited control of heating through questionably functioning wall and mobile heaters and inadequate ventilation with no air conditioning systems creates a risk of further safety concerns. This is particularly the case during winter periods. Given its importance of the safety of both staff and children, maintenance and appropriate funding would need to be looked into in order to amend these areas of concern at the TLC (Jonas & Chez, 2004).

Finally, the internal structure of the TLC has been indicated to have certain areas that create blind spots that may potentially impede supervision of the children at times. This is particularly the case when certain children, especially those who experience high levels of arousal and hyperactivity, may manoeuvre around the unit temporarily out of sight of supervising staff (Cabaniss et al., 2016). These shortfalls justify the need for more thorough supervision from nursing and aid from CCTV cameras to compensate for the creation of blind spots in the unit. (Varcarolis, 2016).

Although the unit standards that addressed this evaluation question were found to be met, the concerns that I have raised in this section arguably illustrate that the TLC's safe and secure environment for the children is under notable threat. This makes it difficult to affirm that the children and staff members are essentially safe and secure within its environment.

Staffing and Training at the TLC

The importance of experienced staff members within the context of child and adolescent inpatient psychiatric units, who are supported with effective and consistent training, cannot be understated (Scholefield, 2007). These individuals provide the means to apply and sustain

collaborative medication which consists of a) specialised treatment from many mental health practitioners; and b) healing relationships between the team and the patients (Jonas & Chez, 2004; Mahoney et al., 2009). I will assess the formulated evaluation questions for this category within the context of the TLC.

Are the staff of the multidisciplinary team provided with effective support and training programmes?

Unit standards which assess the extent to which staff training is provided at the TLC focus on areas of training that are intended for all staff members and areas of training that are regarded as more applicable to a select group of staff members. Furthermore, incorporated with these training programmes are pathways of support (i.e., guidance and emotional and psychological support) for the staff members of the TLC. The majority of unit standards which assess staff training are both Type 1 and Type 2. Overall, the standards that assessed the training programmes offered at the TLC were found to be fully met.

Support for staff health and well-being was found to be established for TLC staff members. One internationally recognised pathway available to all TLC staff members is the Independent Counselling and Advisory Services (ICAS). This organisation provides good employee health and wellness programmes and psychiatric support for employees, to name a few (Bateman, 2010). The service becomes particularly important in periods where employee turnover is high within an organisation. For reasons that were not outlined by the respondents of this research, the case of employee turnover is rising within the TLC. However, the support from ICAS could help the employees make sense of their difficulties that are steering them towards resignation and could offer them solutions that can improve their skill basis (Bateman, 2010). Further research would need to be conducted to investigate whether staff are aware of the service and whether it is utilised. Furthermore, the TLC offers staff wellness through team-building activities that are usually scheduled once every month. This platform allows staff members to engage with and learn more about one another in more informal settings. Despite the offerings being available, the high turnover rate suggests that the TLC investigate reasons for resignation more closely.

In addition to the support pathways discussed above, the TLC implements policies which provide induction (i.e., orientation) for new staff members or temporary agency staff to the TLC

unit. Agency staff members are individuals from independent agencies who are brought in to supplement or temporarily fill in vacancies of a permanent team within an organisation (Massey, Esain, & Wallis, 2009). In the case of the TLC, these staff members are generally trained nurses who may be brought in to help with staff shortages or management of high-risk children within the unit. Although induction programmes are offered for these staff members, they tend to be conducted on the day of the shift. This means that these staff members are constrained with time in order to familiarise themselves with the unit and all its operations (Massey et al., 2009). Therefore, they may be unaware to specific procedures which could lead them to make ill decisions that could affect their performance and possibly the children who are being supported (Adams & Bond, 2003; Massey et al., 2009). As such, I recommend that more attention be paid to inducting agency staff members before they are placed within the unit.

With regard to specific training offered at the TLC, the Intermediate Life Support training is mainly specified for nursing staff. This programme covers medical procedures that need to be well understood and applied. For example, rapid tranquillisation which refers to cases where medication is administered to an individual who is extremely agitated and/or aggressive in order to help them calm down quickly and to reduce any form of risk to the individual him/herself or others (Cotton, 1993). Some other programmes were found to be offered to all staff members. These include, but are not limited to, risk assessment and risk management; Basic Life Support training; and mental health awareness training.

It is, however, unclear whether TLC staff members are being made aware of neither the various programmes nor whether the interventions are being accessed by respective staff members. Problems may arise if staff members are not made aware of training programmes. For example, risk assessment and risk management training provides knowledge and experience in assessing the extent to which a child's displayed symptoms and behaviours may potentially pose a risk on themselves and those they come into contact with (Cotton, 1993). If staff members have little to no understanding and experience of this process, they may overlook certain behaviours displayed by a child as posing a potential risk for causing harm to him/her and/or others (Carroll, 2009). By using this example as reasoning, I encourage the need for management to ensure that training programmes offered for all TLC staff members are publicly advertised, that staff

members are made aware via communication channels and that they are encouraged to access these programmes.

While the TLC does offer effective support and training programmes to its staff members, more efforts are needed to ensure that employees are made aware of the programmes offered and that they are encouraged to access them.

Are there a sufficient number of nursing staff to safely meet and support the needs of the admitted inpatients or day-patients within the unit?

Unit standards that assess the number of nursing staff available to safely support the needs of the children focus on the ratio of nursing staff to children admitted. This ratio is affected by the dependency level of the child who is being supported by the nursing staff. This dependency refers to how much supervision and support the child needs based on the nature of their symptoms and behaviour (Cabaniss et al., 2016). Furthermore, a portion of unit standards assessing this area also addresses the nursing staff's skill level. The majority of unit standards are Type 1. Overall, the availability of nursing staff to safely support the needs of the children admitted were deemed sufficient.

Nursing management for the TLC aims to ensure that there are sufficient numbers of nursing staff available. A minimum of six nursing staff members are shifted daily generally with four nurses on-duty during the day shift and a minimum of two nurses on-duty during the night shift. In specific contexts throughout the programme, such as classroom procedures, a minimum of two nurses are always present to supervise and support the children. The TLC also ensures that an experienced nursing staff member is present when on-duty. With an experienced nurse present, newly qualified and inexperienced staff members have constant support should they require it when carrying out their responsibilities. In periods where the nursing department is short-staffed, plans are made to bring in agency staff members who were addressed in the previous evaluation question for staffing and training. Having a sufficient number of nursing staff is extremely important for psychiatric units, such as the TLC, given the pivotal role they play within the therapeutic milieu environment (Dean et al., 2007). Nurses within the TLC are required to engage with and support the children admitted throughout their daily programmes. Having a sufficient number of nursing staff present ensures that core factors, such as the general

safety of the children, are maintained should any difficulties arise, such as minor injuries (Dean et al., 2007).

One unit standard that was deemed not met related to a review of staff capacity (i.e., number) and skill mix of the team. Reviews of this nature are important because they identify a) gaps in team performance and b) which skill areas of staff members need to be improved on in order to develop a balanced workforce (Thompson & Clarke, n.d.). This should take place every 12 months. Even though the TLC does conduct reviews of team members, a skills matrix is not incorporated in the process itself. The reasons for the exclusion of a skill matrix are unclear at this point. I can understand why difficulties may be placed on the accuracy of a skills matrix. One reason could point to staff-turnover which is on the rise at the TLC. As a result, the accuracy of staff skill levels is affected because staff members may initially participate in the review process but subsequently resign or transfer to the main hospital for reasons that have not been disclosed. However, this reasoning alone cannot justify the overall exclusion of a skill matrix into the review of staff capacity.

Taking the above sections into account, I would argue that there are sufficient nursing staff members available to safely support the needs of the children at the TLC.

Access and Admission to - and Discharge from the TLC

In order for the children to effectively engage with the therapeutic milieu environment of the unit, there needs to be integrity and fidelity in terms of the unit's access, admission and discharge processes (Jonas & Chez, 2004). The responses to the evaluation questions below will illustrate to the reader how the TLC manages to sustain this for their inpatients and day-patients.

Is there equity and diversity of access to the TLC in terms of a child's ethnicity, social status, physical health and location of residence?

Unit standards which assess the above evaluation question of equity and diversity in access include newly introduced and existing patients who are supported in terms of their respective cultural, ethnic and religious backgrounds by the TLC. In this regard, the support provided by the TLC was focused in the areas of access and admission of the children to the unit. The majority of unit standards addressed are Type 1. Reassuringly, most unit standards in this regard were found to be met by the TLC staff members.

Under no circumstances does the TLC reject access and admission into the unit based on a child's ethnicity, social status, physical health and location of residence. This would be, for obvious reasons, highly prejudicial and discriminatory. The main reasons for non-admission and refusal to the unit, which are recorded and documented, are based on whether the child's displayed symptoms and conditions are deemed eligible for treatment within an inpatient psychiatric unit.

TLC staff members try and accommodate children from different backgrounds. Staff members' efforts in this regard may include a) opening up group discussions with the children on how diverse people's backgrounds are which allows them to learn about new experiences; b) encouraging the children to request resources that are custom to supporting and practicing their and their families cultural values; and c) providing equal access to recreational resources (e.g., toys) for the children irrespective of their socioeconomic status.

This process becomes difficult when staff members lack cultural competency (i.e., general understanding and awareness of a person's culture, ethnicity and religious beliefs). Campinha-Bacote (2002) recommends that in order to increase your cultural competency, you first need to improve your knowledge of the person's culture, ethnicity and religious belief in question. Once that first step is completed, you need to then show that level of understanding and awareness to the person him/herself (Campinha-Bacote, 2002). Various strategies are available that may help improve understanding and awareness of different cultural backgrounds. These strategies include group discussions, role-playing exercises and the sharing of clinical experiences between senior staff members, to name a few (Lonneman, 2015).

While the TLC seems to be culturally aware and accommodating, it is important that this is maintained. As such, incorporating some of the strategies discussed above into staff training programmes implemented at the TLC, would benefit staff members greatly, especially the nursing staff who supervise and engage with the children on a daily basis.

A unit standard that was deemed not met was a child's access to an interpreter under circumstances in which language barriers are present. While the TLC unit itself does not have an interpreter, the staff members are competent in a number of indigenous languages. As such, there has never been a need for this service in the TLC. Given languages ties to embedded cultural understanding, having staff members with this level of competency puts the TLC, as a healthcare

provider, in good stead to engage with newly admitted children and their respective parents/carers (Lonneman, 2015). It is important to note, however, that the Red Cross War Memorial Children's Hospital has an interpreter service if needed. So while this unit standard wasn't met, there are various conditions in place which counter this.

Overall, from the information discussed in relation to this evaluation question, it is evident that the TLC does ensure equity and diversity of access to children who are referred to the unit.

Are plans established to outline the continuing needs of the patient post-discharge?

Unit standards that address the final evaluation question for category three include the criteria and policy for formulating discharge plans for the children, conducting discharge meetings and the extent to which follow-up sessions are provided for children who have been discharged from the unit. These unit standards are predominantly Type 1 and 2 standards. Overall, plans for the support of a child's needs were found to be established prior to and post-discharge.

One unit standard which was deemed partially met was related to children receiving follow-up sessions within one week of discharge or within 48 hours if they are deemed at risk. Due to the number of children being attended to in both Outpatient and Inpatient Services, the TLC's mental health professionals experience difficulties arranging follow-up sessions within one week after the child's discharge. These difficulties may comprise of unsuccessful attempts in contacting the parents/carers of the child who had been discharged. Furthermore, the child and their parents/carers may not show up to a scheduled follow-up consultation (Cabaniss et al., 2016). Nonetheless, it is vitally important that efforts to secure follow-up sessions are exhausted, especially if the child in question is deemed at risk. It is important because there are factors in place that can disrupt the progression and development of a child post-discharge over a short frame of time (Cabaniss et al., 2016). These factors may include socioeconomic and social difficulties, such as familial disintegration at home (Cabaniss et al., 2016). Reassuringly, children, who are discharged, that are deemed at risk, are followed-up with as soon as possible by TLC mental health professionals. These follow-up sessions are usually carried out within 48 hours of the child's discharge. However, the follow-up sessions for children who are discharged in general needs to be more consistent (i.e., within a week of the child's discharge).

One unit standard which was deemed not met was related to the availability of Crisis Resolution Teams for the children referred to and/or admitted to the TLC. Crisis Resolution Teams consist of personnel who provide support to individuals at their place of residence (Sjølie, Karlsson, & Kim, 2010). These are individuals who need to be admitted into hospital. These Crisis Teams usually include a variety of mental health professionals, such as social workers, psychiatrists and psychiatric nurses (Sjølie et al., 2010). In terms of support, they can a) visit you in your home or elsewhere in the community; b) assess your needs and assist with teaching self-help strategies (in this case to both the children and their parents/carers); c) administer medication; and d) provide practical help, for example with housing or childcare arrangements (Sjølie et al., 2010). In instances where the child is still admitted into the unit, these teams can work with the unit's multidisciplinary team towards helping the child stay at home or be discharged from the unit more quickly (Sjølie et al., 2010). According to Jacobs and Barrenho (2011), Crisis Resolutions Teams are mainly prevalent across the United Kingdom. Due to our shortage of skills as a developing nation, no definitive evidence is available indicating the presence of Crisis Resolution Teams within South Africa. However, one step in the right direction can be seen with the increasing development of community residential care homes and community liaisons, which form part of the Division of Child and Adolescent Psychiatry (DCAP) in which the TLC is based. As such, with future developments in place, the TLC may hope to collaborate with Crisis Resolution Teams in order to reduce the length of admission for many of its inpatients.

Overall, plans are established at the TLC in order to support the children who are nearing their discharge and those who have already been discharged. However, more consistency is needed from the TLC's mental health professionals in attending to children, who are not at risk, within one week after their discharge.

Care and Treatment within the TLC

Appropriate care and treatment are essential for any psychiatric unit (Jonas & Chez, 2004). Given the multidisciplinary orientation of these units, a child is exposed to diverse forms of care and treatment, as well as education (Mahoney et al., 2009). In this next section, I will address the extent to which a child may continue their education in the TLC and the extent to

which a child and his/her parents/guardians are involved in decision-making that pertains to their care and treatment.

Are admitted inpatients or day-patients able to continue with their education at their academic level within the unit?

Unit standards that address aspects pertaining to the continuation of education for the children admitted focused on the flexibility of the curriculum implemented and the level of schooling support that is provided for these children. The majority of these standards are Type 1 unit standards. Overall, findings suggest that children admitted as inpatients or day-patients are well supported in efforts to continue their education within the TLC, as evidenced by predominantly fully met standards.

The TLC was found to house an adequate schooling and academic component for the children admitted. The curriculum implemented is flexible, balanced and suitable to the needs of the children at their academic level. Their academic level is regularly assessed by teaching staff who liaise consistently with both the children's respective registered schools and their parents/carers on matters relating to the children's academic performance and continuation (Güvenir et al., 2009). The teaching staff of the TLC are able to provide much-needed input and feedback on the children during multidisciplinary team meetings which are scheduled weekly. Much of the input and feedback provided focuses on the child's behaviour in the classroom and how well they are performing academically (Tas et al., 2010). It goes without saying why it is important that the children admitted into the TLC are able to constructively continue with the education.

One Type 1 unit standard that was deemed not met related to whether the continuation of education for 16-year-olds was accommodated in the unit. Children of this age cannot be accommodated overall because the TLC only admits children between the ages of six and 12 and thus this unit standard was not applicable to the TLC.

One concern I will raise pertains to permission for the children to go on educational outings/excursions. Overall, recent outings/excursions have not been carried out because permission has been refuted. The main reason for this is largely due to the development of hospital regulations from management. These regulations usually question the safety of the children when leaving the unit on an excursion, even though they are constantly supervised by

nursing staff. As a Type 3 unit standard, outings are neither required nor expected. Instead, Type 3 unit standards add value to a psychiatric unit by providing additional privileges and resources that benefit the child's experience throughout admission. As such, according to Bennett (2016), educational outings/excursions aid a child's early education by a) exposing them to a range of experiences which allow them to gain a sense of the world around them; and b) allowing them to embrace and learn from unfamiliar settings. With this in mind, I would suggest that more efforts are made by the TLC to inform hospital management of the value that educational outings/excursions provide for the children.

Based on the findings discussed I am able to confirm that the TLC does enable and support the continuation of the children's education during their admission in the unit.

To what extent are admitted inpatients' and day-patients' and their respective parents'/carers' views on their care and treatment taken into account?

Unit standards that address the final evaluation for care and treatment focus on collaborative efforts made by the TLC with both the children admitted and their parents/carers in terms of decisions around general care, treatment, diagnoses, and progress within the programme. Here, progress refers to how well the child is responding to the services offered within the TLC's programme. All of these unit standards are Type 1 unit standards. Overall, the TLC does appear to make a collaborative effort in this regard, some so with a child's parents/carers.

The TLC emphasises treating a child with dignity, respect and compassion, regardless of their social, ethnic and economic background. Reassuringly, this approach forms part of the core ethos or mandate of the TLC in being polite and expressing unconditional care in a safe and secure manner.

In line with treating a child with dignity, respect and compassion, both a child and his/her parents/carers views and input are taken into consideration. These views pertain to matters of the treatment being received by the child or even general engagement between staff members and the parents/carers (Cabaniss et al., 2016). The TLC provides good platforms where parents'/carers'/childrens' views can be expressed. For one, a complaints and compliments box is set-up near the entrance to the unit where views are assessed and acted upon by TLC staff members. Secondly, views can be expressed in family therapy sessions with senior clinical staff

members and in parent feedback meetings which take place regularly throughout the child's admission (Cotton, 1993). In this meeting, the parents/carers also receive updates or concerns raised by TLC staff members pertaining to their child's progress within the programme.

With specific regard to treatment, care, therapy and diagnoses, it was found that a child's views and input can only be taken into consideration to a certain degree. Children at the young age in which they are admitted into the TLC have little capacity to question the treatment, care or therapy they are receiving. In other words, due to their stage of development as minors, they are not yet able to grasp many of the aspects that pertain to their treatment, care or therapy, let alone remember them (Cotton, 1993). Furthermore, these children are seldom in a position where they themselves can request a second opinion on diagnoses that are formulated by the mental health professionals (Cotton, 1993). As such, this unit standard is not necessarily applicable to the TLC.

The information discussed above illustrates that the children admitted into the TLC have very limited involvement in the decision-making procedures regarding their care and treatment relative to their parents/carers.

Information, Consent and Confidentiality within the TLC

Information, consent and confidentiality of patients and their parents/carers play an important part in any unit's compliance with legal and ethical considerations (Varcarolis, 2016). The responses to the evaluation questions below will illustrate to the reader how the TLC complies with these provisions.

Is appropriate confidentiality and consent from parents/carers ensured in order to conduct the required examination and treatment on an admitted inpatient and day-patient?

Unit standards which address the question of consent to examination and treatment, from parents/carers, focus on the consistency of which appropriate consent is sought out and recorded from both the parents/carers and the children. Furthermore, these standards address whether competency to consent is measured. In other words, in the case of the children admitted, their capacity to provide consent, based on their age and stage of development (Thompson & Clarke, n.d.). The majority of these unit standards in the QNIC are Type 1 unit standards. Overall, appropriate consent from parents/carers was found to be gathered by the TLC staff members.

During a child's admission into the TLC unit, the child's parents/carers are provided with detailed information packs that clearly outline their rights to confidentiality. What these details communicate to the parent/carer is who, out of the TLC staff, has access to the information their child shares with the services and under what circumstances the information may be shared or disclosed. Under such circumstances, information shared by the child may be disclosed and discussed during weekly ward round or administrative meetings. These meetings bring all multidisciplinary team members together to deliberate over matters concerning the unit itself and the developments in the treatment of a child admitted.

The findings illustrated that before any information that a child shares is disclosed with TLC staff and before any treatment or therapeutic interventions are initiated with a child, consent from his/her parents/carers is sought out and documented accordingly. The recording of the parents/carers consent is usually carried by the child's key worker or case manager. Knowing that consent is sought and documented is vital to the operations of the TLC given the importance of receiving approval from parents/carers in order to implement treatment for their child (Varcarolis, 2016).

However, four Type 1 unit standards relating to consent were deemed not met. The first standard assessed whether consent for general medication and therapy from the child was recorded. The second standard assessed whether consent for specific treatment and care was sought from the child. The third standard assessed whether the child's capacity to give consent was assessed 24 hours after their admission. The final standard assessed whether the TLC follows a protocol to respond to parents/carers when the child does not provide consent. According to the s. 129.2 of the *Children's Act 38 2005*, children under the age of 12 years may not provide consent to receive, or to not receive, any medical treatment. Instead, s. 129.5 states that parents/guardians may provide this consent should the child fall under the age of 12 years. Given that the TLC only admits children between the age of six and 12, this explains why the TLC does not measure a child's capacity to consent. As such, if these four unit standards were removed based on their irrelevance to the context of the TLC unit, all of the Type 1 unit standards under this category would be met.

Thus, the TLC does seek out and obtain appropriate consent from a child's parents/carers but not from the children themselves due to age restrictions.

Young people's rights and safeguarding of children at the TLC

Ensuring that admitted children and their rights as inpatients or day-patients are safeguarded cannot be emphasised enough due to ethical and legal obligations (Jonas & Chez, 2004). The following section discusses the extent to which a child's safety is ensured within the TL.C. Emphasis is placed on assessing the safety, ethics and legality of behavioural management procedures used by the TLC staff members in resolving incidents of violent and aggressive behaviour and emotion displayed by a child.

Are the staff members operating within a safe, ethical and appropriate legal framework in relation to the use of behavioural management procedures when helping patients manage difficult emotions and behaviours?

Unit standards that address this evaluation question focus on how effective procedures are followed both during and after an incident occurs. These procedures incorporate preventive measures of harm, post-incident reporting and post-incident support for children and staff who are directly or indirectly affected by the incident. All unit standards are Type 1, except for one Type 2 unit standard. Overall, the majority of these standards pertaining to the safeguarding of the children and the nature of behavioural management procedures implemented by TLC staff members were found to be fully met.

TLC staff members reported that effective management techniques for violent and aggressive behaviours, displayed by a child, are carried out. Procedures of effective management include verbal limit-setting whereby staff members make the child aware of their behaviours and why they are unacceptable (Phillips et al., 2011). Alternatively, should the child's behaviour escalate to the point in which physical harm may come unto them or others, TLC staff members safely escort the child to Time Out or 'de-escalation' rooms which help them contain the aggressive behaviours and emotions (Phillips et al., 2011).

After an incident involving violent and aggressive behaviour displayed by a child, TLC staff members reported providing adequate support for both the child who was directly involved and the children who were indirectly affected by the incident. One form of support provided is the facilitation of 'worry groups'. These groups allow the children and staff members to discuss and reflect on the incident that occurred and how it made them feel (Yampolskaya et al., 2013).

As such, the children and staff members are able to make sense of what caused the behaviour and how it affected them (Dean et al., 2007).

There are, however, two areas of my concern. Firstly, newly qualified and inexperienced staff members at the TLC need to make sure that they access behavioural management training. This training provides good knowledge and practical experience of how to effectively assess and manage incidents in which violence and aggression are elicited by the children (Phillips et al., 2011). Even though training of this nature is offered at the TLC to all staff members, the results suggest that the training is not being sufficiently accessed By not having good understanding and practical experience of incidents that involve violence and aggression displayed by a child, staff members may resort to escorting a child straight to the Time Out or de-escalation rooms when this procedure is not deemed necessary, or when the initial steps in the procedure, such as verbal limit setting, could have been implemented in order to help a child contain their violent and aggressive behaviours (Valenkamp et al., 2014). If this happens frequently (escorting a child straight to the Time Out or de-escalation rooms) the children involved may experience more distress in the form of feeling neglected by staff members and peers (Valenkamp et al., 2014). This illustrates why it is important to have more understanding and experience in managing these incidents as staff members are then able to assess the incident and respond appropriately.

The second concern relates to whether parents/carers are informed of any incidents involving their children within 24 hours after the incident occurred. The Type 1 unit standard that addressed this was deemed not met. In order to comply with consistently informing parents/carers of their child's progression in the unit, the parents/carers should be notified of any incidents within the timeframe of 24 hours. By informing the child's parents/carers, it maintains transparent contact between mental health professionals and the respective parents/carers on matters of treatment involving their children (Tessier, 2010). As well as ensures that safe, ethical and legal restraint procedures are implemented by TLC staff members in order to help manage a child's violent and aggressive behaviour. Furthermore, given that these incidents concern the safety and well-being of the child, it would be ethical to notify the parents/carers promptly after the incident has occurred, irrespective of how severe the incident was (Tessier, 2010).

Apart from these two concerns, overall, the TLC does operate within a safe, ethical and appropriate legal framework in relation to the use of behavioural management procedures when

helping the children manage difficult emotions and behaviours. However, I would recommend that behavioural management training be compulsory for newly appointed and inexperienced staff members and that incidents involving management of a child's violent and aggressive behaviour and emotion are discussed with his/her parents/carers within 24 hours after the incident has occurred.

The TLC's Clinical Governance

The responses to the evaluation questions below address important matters related to staff integration and communication as well as the implementation of policies and procedures in the TLC as a four-tier CAMHS strategy. Without these in place, the TLC would not be able to provide many of its services and treatment to its inpatients and day-patients.

Is information collected on clinical matters disseminated accordingly for all staff members to learn from?

Unit standards that assess the extent to which information on clinical matters is made available to staff members focus on incident-reporting and risk management of children and how they were communicated to staff members. Risk management outline the extent to which a child's displayed symptoms and behaviours may potentially pose a risk on themselves and those they come into contact with (Cotton, 1993). The majority of these unit standards are Type 1. Overall, the TLC was found to adequately disseminate information pertaining to clinical matters to staff members. No unit standards were deemed not met.

In terms of sharing the information outlined in incident-reports and risk management, weekly ward round and administrative meetings serve as good platforms in which the information is disseminated to and discussed amongst TLC staff members. Specifically, findings from serious incident investigations within the TLC are engaged with. Incident investigations involve procedures implemented by TLC staff members in order to understand and resolve matters that pertain to the children's behaviour and well-being (Cabaniss et al., 2016; Cotton, 1993). What these investigations inform to the TLC staff are potential areas where the children may pose a risk to him/her and/or others (Cotton, 1993). In addition to engaging with incident investigations and risk management, weekly ward round and administrative meetings all for the staff members to review the TLC's goals and objectives in relation to the progress of treating the children are engaged with.

These meetings serve as good platforms for TLC staff members to reflect on their experiences with the children. In other words, space is created for staff members to share their experiences (Yampolskaya et al., 2013). This process can potentially lead the team to learn from each other and broaden their understanding of a) how to appropriately manage incidents in the unit; and b) how to make sense of a child's symptoms and behaviours that could potentially pose a risk on themselves and those they come into contact with (Yampolskaya et al., 2013).

Thus, the TLC adequately disseminates clinical matters addressed in incident-reports and risk management strategies amongst its staff members.

Does the TLC unit implement a comprehensive range of policies and procedures that provide a role for service that is set in a context of four-tier CAMHS strategy?

Firstly, four-tier CAMHS strategies represent specialised tertiary services, such as the TLC, that provide assessment and treatment for children (and adolescents) with severe mental health difficulties (Maher & Street, 2018). Many of the unit standards in category seven address whether certain policies that outline how procedures pertaining to services, such as admitting a child into the unit, conducting weekend programmes and carrying out incident investigations, are expected to be carried out. The unit standards are predominantly Type 1 unit standard. A few standards are represented as Type 2. Overall, the majority of policies and procedures within the TLC were found to be fully met.

The TLC has established policies and procedures for the following: admissions of children into the unit; management of violent and aggressive behaviour in children; the use of rapid tranquillisation on children; clinical risk assessment and management; serious incident investigations involving children; management of bullying and those affected by bullying; the use of electronic equipment and the internet by children; the searching of a child's property; children who are absent without leave; and the management of physical health emergencies. Given that I have already discussed many of these areas in previous sections; I will discuss the policies and procedures of areas in which no discussion has taken place.

The use of rapid tranquillisation refers to procedures in which medication is administered to an individual who is extremely agitated and/or aggressive in order to help them calm down quickly and to reduce any form of risk to the individual him/herself or others (Cotton, 1993).

This procedure is outlined in the TLC's Chemical Restraint Policy. However, this procedure has rarely been used on the children within the TLC.

In terms of managing bullying and those affected by bullying, more informal procedures are carried when bullying occurs. As such, there are no written procedures that are expected to be followed by TLC staff members. Instead, TLC staff members are encouraged to manage bullying by facilitating group discussions amongst the children, similar to the 'worry groups' introduced in the previous section on young people's rights and safeguarding children. Through these discussions, it is hoped that the unacceptable bullying behaviours can be addressed and strategies on how to positively engage with peers can be taught to the children (Cotton, 1993).

In terms of conducting searches of property, nurses at the TLC routinely check the children's and visitor's property, ethically, for any dangerous and risk items, such as weapons. Anything brought by the parents/carers of the children is handed over to the staff members on duty. This is an important procedure and policy to maintain. If these searches were not conducted, dangerous objects brought in by a child and/or visitors could pose the risk of harming the child and others in the unit (Cabaniss et al., 2016).

No details that outlined the policy and procedures to follow for children who are absent without leave were provided by TLC staff members. What I mean by absent without leave is that in some instances, children who head home for the weekend from the unit, end up not returning to the unit at the start of the new week. Their absence, in this case, was not made aware of to the TLC staff members who were preparing for their return to treatment.

Based on the management of medical emergency policy, it is standard practice for staff members to be aware of the procedures to carry out should a child experience an acute physical emergency. According to Cotton (1993), acute physical emergencies generally consist of threats to an individual's long-term health. Emergency contact details are readily available to TLC staff members. Furthermore, support is actively provided by the medical doctor on call who is usually based in the psychiatry department of the Division of Child and Adolescent Psychiatry.

Evidently, the TLC has established policies and procedures for important areas that relative to the provision of their services. However, three policies and procedures were deemed to be not met largely due to their irrelevance to the unit itself. Firstly, one Type 1 unit standard addressed a protocol in which the team must follow in cases where a child discharges him/herself

from the unit. Given the age appropriateness and developmental level of children as previously highlighted in the *Children's Act 38 2005*, children in the TLC are in no capacity to carry out self-discharge. In other words, they are unable to understand how to carry out this procedure of discharge.

A second Type 1 unit standard, deemed not met, addressed a policy on the use of the internet for children within the unit. Internet use for children within the unit is not permitted, nor recommended at their age level. The reasons for not allowing this were addressed in question one on the environment and facilities of the TLC (Are the premises and the necessary facilities and resources of the TLC inpatient unit designed and managed to ensure that the inpatient or day-patient's rights, privacy, and dignity are respected?).

A third Type 1 unit standard deemed not met addressed a policy on the management of patients who may be abusing drugs and alcohol. Data providers from the TLC highlighted the presence of guidelines from the Western Cape Department of Health on the management of drugs and alcohol in patients. These guidelines were not elaborated on by TLC staff members. However, no distinct policy was found to be present. Due to the rarity of children admitted into the TLC unit who are found to be using drugs and/or alcohol, a policy has never been deemed necessary. However, according to Charles (2018), drug and alcohol usage is found to be present in children as young as 10 years old within South Africa. This is in conjunction with the surge of general child to adult patient admissions for drug and alcohol abuse to treatment centres from 8787 in 2016 to 10047 in 2017 (Charles, 2018). As such, it may be argued that the use of drug and alcohol in minors, who are referred to units such as the TLC, cannot be ruled out. This is especially the case if these children are using when they are at home on weekends or during the school holidays. Therefore, I suggest that a formal policy on managing children who are abusing drugs and/or alcohol needs to be implemented to safeguard the children against any use or potential use of drugs and/or alcohol.

Thus, the TLC does implement a range of policies and procedures that are relevant to their service provision as a four-tier CAMHS strategy. However, more attention needs to be paid to implementing a policy and procedure for drug and alcohol abuse.

Summary

Overall, it is evident that the TLC unit has satisfied many of the unit standards, across the seven categories of the QNIC. What is important is that the majority of these unit standards from each category are Type 1 and 2 unit standards which are required and expected from an inpatient psychiatric unit respectively. However, there were some unit standards that were either deemed irrelevant to the context of the TLC unit or were simply not adequately satisfied by the TLC. From these unit standards that were not adequately satisfied, I have formulated some recommendations that could help in rectifying and improving the TLC's service quality within certain areas. These will be summarised in the next section.

Recommendations

Given that the overall goal of the evaluation was to identify areas within the TLC's therapeutic milieu environment that may need improvement, this section provides recommendations that could be utilised to improve service quality. The recommendations are based on findings from the process evaluation scope and have already been discussed in the previous section. The key recommendations suggested by the evaluator are highlighted below:

- The evaluator recommends that the child's personal information is stored electronically and/or higher security measures to control access to the filing cabinets housing the information are implemented. This is important to prevent any possible infringements on patient confidentiality and dissemination of information to unauthorised individuals.
- In order to help reduce potential risk to children's safety from other children's behaviour who have assessed as a risk and to benefit a child's need for private spacing, single and separate bedrooms may need to be implemented.
- More access and manoeuvrability within the unit is needed for individuals with physical disabilities.
- In order for newly appointed and existing staff members to improve their level of experience within the context of inpatient psychiatric units, more efforts are needed to make these staff members aware of available training and support. Furthermore, more encouragement is needed to ensure that these staff members are accessing the training and support available to them. This is particularly important for staff members who have

little experience with safe and ethical behavioural management of children within the unit.

- What can further be incorporated with the training programmes provided are cultural competency strategies that help the staff members improve their understanding and awareness of different cultural backgrounds in order to benefit their engagement with the children and their parents/carers.
- Follow-up sessions with children who are discharged from the unit need to be ensured within one week of their discharge. This mainly applies to children who are not deemed at risk.
- The benefits of educational excursions for the children need to be communicated to hospital management in order to increase the likelihood of permission being granted.
- Irrespective of the severity of an incident that a child is directly involved in which may require behavioural management, his/her parents/carers need to be informed of the incident within 24 hours of its occurrence to ensure transparent contact between the TLC and the parents/carers.
- Finally, a more clear policy and procedure, apart from the Western Cape Department of Health guideline, needs to be established, particularly for children who may be suspected of using drugs and/or alcohol at home.

Limitations

There was one area of data provision that I will address as a limitation to this process evaluation. Based on the fact that data on the unit standards could not be collected from the parents/carers of the children involved in the TLC, a limitation in data collection was created. As indirect participants to the programme, collecting responses from the perspective of a parent/carer of the child receiving the services offered by TLC may have enriched the data collected on the unit standards. For example, parents/carers would have more exposure and experience with the environment and facilities; and care and treatment at the TLC. In this case, both the data on to what extent a standard was met, and the qualitative comments could have illustrated either more agreement or disagreement on responses to these unit standards. Using TLC staff alone presents a biased view from employees. While I tried to counter this limitation by asking for proof and evidence to support the ratings made, this wasn't possible for all unit

standards. Another limitation I experienced was encapsulated by the limited number of participants (i.e., multidisciplinary team members) who were a) primarily active in the TLC's inpatient psychiatric unit for children; and b) long-term members of the team who could provide even more enriched and quality data that could be utilised for comparison. In this regard, the assessment of the fidelity of the QNIC may be argued to have been negatively affected. While there was a small number of data providers, every member of the multidisciplinary team was included and as such this limitation was unavoidable. A final limitation was the fact that little research is documented which presents the utilisation of the QNIC to establish international standards of service quality specifically within the context of child inpatient psychiatric units. The research found uses the QNIC in adolescent and adult units. Therefore, it was not possible to compare results of previous research to the results of this study.

Critical reflection

With specific regard to the responses provided by the participants in this evaluation, the question of their validity and objectivity cannot be overlooked. This is largely due to the bias created by recruiting solely TLC team members who are largely made up of mental health practitioners. Their responses were all self-reported. Unfortunately, given the nature of the research, this was unavoidable. The nature of the unit standards in the QNIC requires the data provider to have sound knowledge of and experience with the unit and its practices. Other than parents/carers, employees are the only individuals who would have been able to provide responses to the research. For tangible unit standards, observations confirmed the data provided and/or data providers presented evidence to support their responses. For intangible unit standards, however, the evaluator was forced to rely on the integrity of the participants in providing the information. The use of a qualitative measure was also incorporated as a way to support and provide reasoning for the responses obtained.

Conclusion

Based on the findings, the aim of assessing and critiquing the standards of mental health service and quality of programme implementation of the TLC against internationally recognised unit standards of service quality was accomplished. Overall, when it comes to standards of service quality that pertain to a unit's a) staffing and training; b) admission, c) access and discharge; d) care and treatment; e) information, consent and confidentiality; f) young people's

rights and safeguarding children; and g) clinical governance, the TLC's service quality favours well as a local child inpatient psychiatric unit. The area requiring the most attention is the environment and facilities in which services and programme implementation are conducted. Subsequent to these findings addressed, it was recently brought to my attention that the TLC would be in the process of re-establishing its services and programme for child inpatients and day-patients at the main Red Cross War Memorial Children's Hospital. The reasons for this transference of services pertained to concerns surrounding the internal structure of the physical unit and whether it created a safety risk for both the staff members and the children admitted at the TLC. Nonetheless, this evaluation contributes to the literature on inpatient psychiatric units. It does this by illustrating the extent to which the only recognised unit in the Western Cape is able to implement its multidisciplinary treatment programme within a therapeutic milieu environment and how the quality of its programme compares on an international scale.

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Appendix A

Permission Letter

School of Management Studies

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Telephone +27 21 650-5218

Sarah.Chapman@uct.ac.za

TO WHOM IT MAY CONCERN

Thank you very much for your willingness to enable one of our students to work on the evaluation of a programme from your organisation as part of their 50% Master of Philosophy specializing in Programme Evaluation dissertation. We appreciate your contribution to the education of our students. At the end of the dissertation examination process, you will receive a copy of the dissertation in the form of a useful evaluation report which will enable you to make informed decisions about your programme. We also undertake to assure you that the student will display professional behaviour at all times while working in your organisation or on your programme.

The student will need programme information from you and we request that you or a designated person meet with the regularity to provide access to this information. Your cooperation in this regard will ensure that the student provides you with a high quality evaluation, and will help to ensure the student meets deadlines. In order for us to keep track of the quality of the student's work we request that you copy the student's supervisor(s) in all correspondence, and that you reach out to the student's supervisor(s) directly should you have any concerns regarding the student's work.

Please note that our students are required to work within the ethical framework of the Faculty of Commerce when collecting information from programme documents, programme stakeholders and programme beneficiaries. This framework deals with the anonymity of data sources,

sensitivity when requesting information from people and responsibilities when reporting results. Please also be aware that the student's work will fall within the intellectual property specifications of the University of Cape Town. You can familiarize yourself with the terms of UCT's IP Policy here (https://www.uct.ac.za/downloads/uct.ac.za/about/policies/intellect_property.pdf). This policy explains that copyright to any publications stemming directly from the students research dissertation is automatically assigned by UCT to the author (in this case, the student). A student also owns the copyright in their thesis or dissertation.

In order to comply with the rules of the Faculty of Commerce, we request you sign below to indicate that you are aware of the research / evaluation been undertaken by one of our students in your organisation, and that you will support the student to access programme data, records and recipients if applicable.

Yours sincerely,

Associate Professor Sarah Chapman

COURSE CONVENOR: MPhil Programme Evaluation and PhD in Programme Evaluation

AGREEMENT FOR STUDENT TO UNDERTAKE RESEARCH AND/OR AN EVALUATION IN YOUR ORGANISATION:

_____	Manager: Medical Services	25/06/2019
Signature of Authorised Person	Organisation	Date

Hospital Research Review Committee; Red Cross War Memorial Children's Hospital Psychiatry Unit

Name of the programme student will evaluate (if applicable)

Appendix B

Informed Consent Form

UNIVERSITY OF CAPE TOWN

DEPARTMENT OF PROGRAMME EVALUATION

An evaluation of the Therapeutic Learning Centre: a child inpatient and day-patient psychiatric unit.

1. **Invitation and Purpose**

   You are invited to take part in this study which is conducting a process evaluation of the child inpatient and day-patient psychiatric unit known as the Therapeutic Learning Centre (TLC). I am a registered Masters research student from the Department of Programme Evaluation at the University of Cape Town.

2. **Procedures**

   - If you agree to participate in this study, I will provide you with a questionnaire/systematic checklist which you will be asked to complete that addresses unit standards of service and implementation quality of the TLC. In completion of the above, you will be asked to provide any available evidence that supports your response to the unit standards and to provide qualitative explanations (i.e., descriptive comments) as to why the standard has been met or why the standard has not been met.
   - The completion of questionnaire/systematic checklist should take approximately four to six hours.
   - Participating in this study is completely voluntary. You are free to withdraw from the interview proceedings at any time with no penalty or any other form of consequence.

3. **Risks, Discomforts & Inconveniences**

   - This study poses a minimal risk of harm to you as a participant.
   - Speaking about your experiences throughout your employment and contribution to the goals and outcomes of the TLC could bring up sensitive issues regarding the difficulties you may have experienced and still may experience within the

field of child mental health and well-being. This could potentially be emotionally distressing for you. However, you as the participant will decide what information you would like to disclose in response to the questions during the interview. You will not be obligated to disclose any information that you do not feel comfortable speaking about.

- You may be inconvenienced by giving up your available time to participate in this interview process.

4. **Benefits**
    - Participation in this study provides you with the opportunity to reflect on your experience of engaging with and implementing support for children with mental health difficulties and provide insight into the nature of the quality of service that the therapeutic milieu environment of the TLC has had on admitted inpatients or day-patients.
5. **Privacy and Confidentiality**
    - All information that you share will be kept strictly confidential.
    - You will remain anonymous throughout the research process.
    - You have the right to request the removal of any information that you have shared.
    - Only I, the researcher, and my university supervisor will have access to the data recorded.
6. **Contact Details**

    If you have questions or complaints regarding the study, please feel free to contact Dr. Carren Duffy at the Department of Organisational Psychology, University of Cape Town (UCT) on 021 650 3428

7. **Signatures**

{Participant's name}_____ has been informed of the nature and purpose of the study's procedures outlined above which include any risks involved in his/her participation. He/she has been provided with time to ask any questions related to the study and these questions have been answered to the best of the researcher's ability. A signed copy of this consent form will be made available to the participant.

_____

Researcher's Signature Date

I, the participant, have been informed about this evaluation study and understand its purpose, potential benefits, risks and discomforts. I agree to take part in this research process as a participant. I am conscious of the fact that I am free to withdraw this consent and withdraw from the research process at any time. No penalty or loss of benefits will be elicited.

_____

Participant's Signature Date

Appendix C

Chronological Order of Unit Standards for the Environment and Facilities (Category 1)

	Unit Standards	Mode	Qualitative Reasoning
1.1.1	The Unit/unit entrance and key clinical areas are clearly signposted	2	There are some sign noting parking for the TLC but very limited. There is no clear signposting from any of the entrances. There is one (maybe two) partially hidden signposts. There are often people asking how to get to the ward. There are many people on the campus who are not even aware that there is a ward on the premises. Signposting is generally poor. No public transport parking and parking not clearly allocated. Security guards are visible at the gate to guide the visitors and doctors to appropriate places and the parking area is clearly visible. Inside the unit, doors are clearly marked to indicate the names of occupants and also the clinic room is also marked and locked at all times. The main entrance to the department is marked the Division of Child and Adolescent Psychiatry and only when you enter the campus the Therapeutic inpatient unit is marked clearly. External signage is in English, some internal signs are in Afrikaans and IsiXhosa.
1.1.2	All rooms are kept clean.	3	Cleaning staff regularly ensure that the TLC is kept clean. I think that for the most part the TLC is a clean environment. The bedrooms are often untidy and dirty. The playroom is always dusty and dirty. The classroom is always clean and tidy. Very good cleaning staff There is a designated cleaning staff member who is fully responsible for the unit each day. The housekeeper sees to it that appropriate cleaning material is used for different areas like bathrooms, kitchen and offices. The general cleaning staff has a set routine and supervisor, but the furniture needs to be upgraded. Appearance of the ward; daily cleaning schedules and checks are housekeeping staff are signed.

Chronological Order of Unit Standards for the Environment and Facilities (Category 1) Continued

	Unit Standards	Mode	Qualitative Reasoning
1.1.3	The unit is in a good state of repair and maintenance is carried out in a timely manner.	2	The TLC building is in a significant state of disrepair, posing a risk to staff and patients. There are leaks throughout the building. The building is not fit for purpose. It was never meant to be a child psychiatry ward. Minor repairs made with ease, higher cost items take time to fix The building is old and neglected and as such, when it rains, the classroom, passages, boardroom and other areas become wet and cold. The matter has been reported with no positive response for years now. The Therapeutic Learning Centre is geographically removed from the main hospital which results in services/repairs being performed at the main hospital as a priority and TLC being neglected. Repairs can take up month's even years to be done with numerous requests from TLC staff for the repairs to be granted as urgent. Generally, minor building maintenance/repairs e.g., plumbing related work is done relatively quickly, however major repairs e.g., roof repairs take a long time. Currently parts of the building roof are leaking i.e., TLC boardroom, one of the staff offices and OT entrance to mention a few.
1.1.4	Staff members and young people can control heating, ventilation and light or have access to support from facilities.	1	The TLC can get very cold in winter and very hot in summer. While there are some heaters and some and they are not sufficient and staff and patients have regularly commented on this. The heating is provided through broken heaters. There is not good ventilation. Service is good. Windows do not close properly and as such it's extremely cold in winter and very hot in summer. Ventilation needs urgent attention. We also need wall heaters that are functional so as to keep the kids warm in winter. But the place needs a complete overhaul or maybe re-locate to a new environment. The TLC building was not constructed for inpatient care and was initially an outpatient department. TLC has adequate lightning but lacks an air conditioning system which results in the unit being extremely hot in summer and very cold in winter. Mobile and wall mounted electric heaters are locally controlled; mobile electric fans are also locally controlled. The building doesn't have an air conditioning system.

Chronological Order of Unit Standards for the Environment and Facilities (Category 1) Continued

	Unit Standards	Mode	Qualitative Reasoning
1.1.5	Waiting rooms/areas are provided.	2	There is a foyer in the TLC that serves as a pseudo-waiting room though isn't specifically designed for that purpose. The waiting area is in the passage. Two waiting areas at OPD and waiting area at TLC TLC is not designed to cater for visitors I guess because we have OPD area that has a fully functional waiting room area. We have created just a small area in the foyer that we use as a waiting area. The TLC doesn't have a waiting room. Parents, visitors and the public have to make use of the OPD waiting rooms which are located on the premises but outside of TLC. The ward has an identified waiting area.
1.1.6	There is indoor space for recreation which can accommodate all young people.	2	One of the bedrooms is converted into a play area. There is not an area exclusively designated available for play indoor. There is indoor space for recreation although it is poorly designed and not clearly fir for purpose e.g. the TC room is in one of the bedrooms. Play room and room for table tennis. The play area is also used as a bedroom and the other so cold play area is used as the visitor's area and also tea area during school break time. The recreation room is often used as a bedroom as well to staff to observe patients to be close to the nurse's station. The unit has a smaller are where patient can play table tennis and have snacks during rainy weather. The same room is also used as a room for visitors during designated visiting times. The ward uses the internal recreation area as a multipurpose area, thus at times the space is not enough.
1.1.7	There is a designated outdoor space.	3	While there is fairly large area for children to play there is only a jungle gym and set of swings available. Lovely outdoor space. Good outdoor space. There is a small park in the courtyard that is used as a playground. However, we do not have enough play material to use as entertainment for the kids. The unit has a reasonable outside garden area with jungle gyms, but the bigger area is tarred, minimal grass area. The external play area is easily and safely accessible to the young people in the ward. It is child friendly with a variety of activities that the children can engage in.

Chronological Order of Unit Standards for the Environment and Facilities (Category 1) Continued

	Unit Standards	Mode	Qualitative Reasoning
1.1.8	Young people are able to access safe outdoor space every day where clinically appropriate.	3	The therapeutic programme allows regular play outside (unless weather or other clinical factors determine otherwise). Children spend a lot of time out of doors and there is plenty of exercise space Part of TLC day routine. There is a clearly distinguished courtyard which is locked at all times. Children are always accompanied by an adult when they go outside. These are supervised by staff and form part of the programme. During very busy days, especially when patients presents with challenging behavior there isn't always enough staff to accompany the patients to the outdoor space. Outdoor space is safely accessible to the children admitted in the ward. Outdoor space can be directly accessed from the ward, it has perimeter/boundary fencing to ensure the safety of children. It is exclusively used by children admitted in the ward.
1.1.9	The unit contains rooms for individual and group meetings.	3	The boardroom allows for meetings - individual and group. There are a number of rooms for individual and group meetings. Nurses' offices are used to interview kids and the playroom is used for things like 'worry groups'. The unit only one individual counseling, but it's the clinical psychologist's office. The other room are open space with no privacy e.g. nurse's station, board room dining room. Identified space is available for children to be interviewed individually and with parents, and there space for group meetings.
1.1.10	The Unit/unit has a designated dining area, which is available during allocated mealtimes.	3	There is a designated dining room. There is a dining room. A dining room table draped in a table cloth and comfortable chairs are clearly visible. Place mats are also provided to create a conducive environment to enjoy the meals. The unit has a dining room, but furniture needs to be upgraded. The ward has a designated dining area, which is utilised for its purpose.

Chronological Order of Unit Standards for the Environment and Facilities (Category 1) Continued

	Unit Standards	Mode	Qualitative Reasoning
1.1.11	There is designated teaching space for education which can accommodate all young people in the unit.	3	There is a teaching space available for the children. On site school. The unit has a fully functioning school that is managed by the department of education. There is a qualified teacher and a classroom assistant. The teaching spaces are the class room, art room (outside room) and the occupational therapy room, There are no other space for informal discussion e.g. afterhours when the therapeutic programme has ended. The ward has a designated teaching space which is used as a classroom, a teacher's office and a library area.
1.1.12	In Unit/units which have a seclusion room, it must meet the following requirements: • The room must allow for clear observation; • Be well insulated and ventilated; • It must have direct access to toilet/washing facilities; • The room must be safe and secure – it does not contain anything that could be potentially harmful; • It must include a means of two-way communication with the team; • It should have a clock that young people can see.	2	I'm going to call out Time Out rooms de-escalation rooms (referred to in a later question) rather than seclusion rooms as described here. With that definition we don't have seclusion rooms. The room must allow for clear observation; YES • Be well insulated and ventilated; NO • It must have direct access to toilet/washing facilities; NO • The room must be safe and secure – it does not contain anything that could be potentially harmful; YES • It must include a means of two-way communication with the team; NO • It should have a clock that young people can see NO. Timeout space available but seclusion not part of standard practice as clients are under 13yrs of age. We have a time-out room and not seclusion room. A child is taken in there or voluntarily goes in there to soothe themselves and only for a short period of time. It is clean, well ventilated and safe. There is always a staff member to supervise the child until she comes out. The TLC accommodates children under 12 years old and doesn’t have a seclusion room, but make use of a time out room as part of behavior modification and containing patient uncontained behavior. The ward has two timeout rooms where patients can be afforded privacy from other patients when they are severely distressed and uncontained. Staff are able to observe the patient at all times through a viewing window and CCTV monitoring. The space is safe and secure and doesn't contain anything which could cause harm to the patients or others; be adequately lit and ventilated.

Chronological Order of Unit Standards for the Environment and Facilities (Category 1) Continued

	Unit Standards	Mode	Qualitative Reasoning
1.1.12	All units must have an appropriate policy which highlights how a service secludes. This should include the threshold at which a young person would be transferred to a more secure environment.	3	We have a policy that describes in broad terms how to manage a child going to Time Out and what might lead them to go there. Only has time out policy. No policy for transfer to more secure unit. Seclusion not part of standard ward practice. We have time-out policy and the rule of thumb is always that of containment for a short period of time then out. Though the unit doesn't have a seclusion room it has a document that indicates that TLC is a 72 hour admission. If patients become completely unmanageable and need a more secure admission to another hospital there is guidelines to how it should take place according to the Child Care Act No 38 of 2005 and Mental Care Act no 72 of 2002. The ward has a timeout SOP.
1.1.13	There is a designated area or room (de-escalation space) that the team may consider using, with the young person's agreement, specifically for the purpose of reducing arousal and/or agitation.	3	We have a Time Out room that children go to (not always with their agreement). Only has time out room. This is sometimes used as de-escalation room We have a time-out room area that is used under supervised care to help contain the kids and prevent them from hurting themselves and others. TLC has 2 Time out rooms staff are constantly trained re management of patient's aggressive and acting out behaviour. Due to limited space, the ward does not have a dedicated de-escalation space; timeout rooms are also used for this purpose.

Chronological Order of Unit Standards for the Environment and Facilities (Category 1) Continued

	Unit Standards	Mode	Qualitative Reasoning
1.1.14	All young people can access a range of current age appropriate resources for entertainment, which reflect the Unit/unit's population.	2	Though there are a range of resources and activities available, many of them get broken quickly and there is a limited access to electronic equipment (e.g. computers or Ipads). I do not think that the unit caters appropriately for all age ranges. One of the difficulties faced by the unit is that there may be 7 year olds and 12 year olds in the ward at the same time. I do not think that there is sufficient age appropriate entertainment for the older children. In fact I do not think that the entertainment has been carefully thought out to meet the needs of the children. We could benefit from more and more technology for children to access information. It has been difficult to entertain the kids lately due to lack of play material. This has been due to lack of funds but also when we do get some play material; children also destroy these when they experience rage and just undergoing some difficult emotions. The department has a resource room, but it is situated in the OPD are and not readily available to the TLC patients. Patients will have to leave the TLC to the OPD areas to access the resource material. Children have access to age appropriate resources for entertainment such as toys, games and art and craft play materials; and age appropriate animation DVDs. However, the ward doesn't have an extensive resource stock particularly for older children e.g., tween ages of 11-12yrs old.
1.1.15	One computer is provided for every two young people in school	2	We have at least 6 patients at a time meaning there isn't always the 2:1 ratio needed to be fully met. I don't think that there is one computer for two children The capacity for in-patient admission is 6 and we have 3 computers in the classroom. The school only has 4 computers, which results in two patients of the six having to wait to use the computer causing a delay and contributing to patient's frustration. The TLC classroom has desk top computers and access to a lap top computer.

Chronological Order of Unit Standards for the Environment and Facilities (Category 1) Continued

	Unit Standards	Mode	Qualitative Reasoning
1.1.16	Young people use mobile phones, computers, cameras and other electronic equipment on the Unit, which provide access to the internet and social media. This is subject to risk assessment and is in line with local policy.	1	I'm not sure if there is internet on the computers in the classroom. They do not have access to internet in the ward. They do not have access to phones Clients are under 13yrs and do not have access to personal electronic devices. Children are not allowed to bring any form of expensive items except for one favourite toy that that they can use as a form of comfort away from home. Patients are only allowed access to computers within the class room but no access to internet. Children have access to computers for educational purposes but not for recreational use. Smartphones and cameras are not allowed in the ward for risk management purposes and in accordance with local policies.
1.1.17	Each young person has the educational materials required for continuing with their education.	3	In many ways the classroom and its resources are far superior to many of the classroom facilities that the inpatients would usually be exposed to. Although it is noted they only do a reduced curriculum (given that the focus of their admission is not education). There is a qualified teacher employed by WCED at the TLC. Material is obtained from their school .Parents bring it to the centre or the school is asked to forward it by email. The TLC school is equipped with text books which cover from Grade R to Grade 7.We use the Caps aligned documents and assessments. We concentrate on Home language, First Additional Language, Mathematics and Life Skills. All study material is available and is supplied by the department of education. Our unit teacher also liaises with the learner's class teachers to get sense of where the child is at academically so that proper school placement on discharge can be enforced. The teacher and psychologist make contact with the child's school. Parents are encouraged to collect the school with his/her school. The teacher or psychologist with visit the child's or new school to gain collateral. Western Cape Education Department curriculum implemented by the Red Cross Primary School. The educator will liaise with the mainstream school to assist with work and the educator will also provide work in line with the child's specific needs.

Chronological Order of Unit Standards for the Environment and Facilities (Category 1) Continued

	Unit Standards	Mode	Qualitative Reasoning
1.1.18	There are sufficient IT resources (e.g. computer terminals) to provide all practitioners with easy access to key information, e.g. information about services/conditions/ treatment, young people records, clinical outcome and service performance measurements.	2	Perhaps not sufficient computers available with access to clinical record (although the local systems mean most records are kept on paper not electronically. There is only IT access to blood results. Special investigation results available electronically but paper record keeping are the standard. Every area is supplied with computers and research tools are available in the form of internet should we require any kind of information. Not all staff has access to computers and computers are not readily upgraded. Practitioners have access to computers and intranet and/or internet either via Provincial Government of the Western Cape (PGWC) and UCT internet terminals.
1.1.19	There are facilities for young people to make their own hot and cold drinks and snacks where risk permits.	3	Given their age children are accompanied where risk permits. Fully functioning kitchen available Snack time part of daily ward routine. Children are from time to time supervised in baking their own muffins or biscuits for enjoyment with tea or milo during snack time. The only area is the kitchen, enough is not always available to accompany individual patient, but groups instead. The ward has a designated kitchen area where hot and cold drinks and snacks are prepared. Housekeeping and nursing staff assist with preparation and serving of drinks and snack. The hospital main kitchen provides prepared meals for the children.
1.1.20	Parents/carers have access to refreshments at the unit	1	Parents are not routinely offered tea or other refreshments when they visit. Parents not offered or have access to refreshments. They usually bring their own. We do not cater for parents. There is a staff tea room for the staff members only. The main kitchen is only for use of the patients and the staff. The closest shop for parents is 10 minutes away from TLC.

Chronological Order of Unit Standards for the Environment and Facilities (Category 1) Continued

	Unit Standards	Mode	Qualitative Reasoning
1.1.21	Units can provide information for families about local accommodation.	1	This is not done. Not available. Certain members of staff will be able to recommend accommodation, most patients are local. No child is turned away due to lack of parent accommodation. The hospital has parent accommodation. The TLC forms part of RCWMCH, The only parent accommodation is on The RCWMCH which are 10 minutes away from TLC. This will results in parents having accommodation away from the children and those without transport will have difficulty during rainy weather. The hospital has parent quarters to accommodate parents who need onsite accommodation.
1.1.22	Unit/unit-based staff members have access to a dedicated staff room.	3	There is a designated staff room available. Staff tearoom available. We have day/night hand-over room where each child's day or night condition is discussed in depth. It is a private space with a monitor to observe the children's activities but is also within the children's reach in cases of emergency. The staff room isn't used by all staff. The ward has a dedicated staff room, where they can sit during tea and lunch breaks.
1.2.1	There is a visiting policy which includes procedures to follow for specific groups including: • Children; • Unwanted visitors (i.e. those who pose a threat to young people or to staff members).	2	There is certainly an understood and implemented policy about visiting hours. I'm not familiar if there is a written policy about visiting procedures. Policy document. There is a visiting policy bit does not include children or unwanted visitors. Visiting and planning around visiting forms an important part of clinical care. We admit a lot of children with social problems and we try to involve external social workers to join forces with ours so as to devise a plan that will benefit the child but also respect the family members in the process. The TLC only has visiting On a Wednesday afternoon and Saturdays and Sunday which are different from the main hospital where visiting is daily and at night during designated times. RCWMCH and ward visiting procedures and policy.

Chronological Order of Unit Standards for the Environment and Facilities (Category 1) Continued

	Unit Standards	Mode	Qualitative Reasoning
1.3.1	All young people's information is kept in accordance with current legislation. *Guidance*: *Staff members ensure that no confidential data is visible beyond the team by locking cabinets and offices, using swipe cards and having password protected computer access*.	2	Information is kept in cabinets and in separate rooms. The cabinets are not locked routinely and there is no swipe card control. Files are kept in unlocked cupboards. Not all staff has internet access. When patient information is sent it is not sent password coded. Documents are kept private, and in separate room but are not locked away. Although cupboards are available, and are kept in private spaces, they are not under lock and key. The patient files are being kept within specific rooms which are not locked. No swipe card to doors. Patient information and data is kept confidential. All personal files and confidential information is kept in environmentally controlled locations when unattended - in storage cabinet located in a designated area within the ward, where it is only accessed by clinical and nursing staff. Computer systems are password protected.
1.3.2	The environment complies with current legislation on disabled access. *Guidance: Relevant assistive technology equipment, such as hoists and handrails, are provided to meet individual needs and to maximise independence*.	2	There is a wheelchair access available to the TLC. I'm not familiar enough with current legislation but I imagine if there is the TLC building is unlikely to be fully compliant. Some facilities are suitable for the disabled. Toilets and showers are not disabled friendly Building was not designed for special needs but accommodation will be made by TLC staff. I don't think it's fully user friendly. The environment does not cater for people with disabilities. The main entrance to TLC has a ramp, but the toilets are not wheel chair friendly. TLC doesn't have a designated disabled parking. Main entrance has a wheelchair access. However, other areas such as bathrooms are not wheelchair friendly, thus the ward environment does not fully meet this standard.

Chronological Order of Unit Standards for the Environment and Facilities (Category 1) Continued

	Unit Standards	Mode	Qualitative Reasoning
1.3.3	All young people have single bedrooms according to need.	1	There are only two dedicated rooms (and one additional room that also serves as a play room). All children share bedrooms. Occasionally they are placed in a single room but this is determined by the numbers of beds filled at any one time or the ration of boys to girls. The principle of single rooms does not apply At times children of similar sex may have to share a bedroom. Infrastructure does not allow. There are only 2 rooms available in the unit, one caters for 2 kids and one caters for 4 kids. Patient share rooms as the TLC only has 2 big bedrooms, one three bedded and one two bedded. The fifth bed is in the patients' recreation/TV room. The current ward space is not built for purpose, it doesn't have single bedrooms. Bedrooms are two/three-beds bedrooms; however, children who need intensive psychiatric care are singularly accommodated, according to clinical need and risk assessment.
1.3.4	Young people have separate bedrooms, toilets and washing facilities, split according to self-identified gender. Young people do not pass through areas occupied by members of the opposite sex at night unsupervised to reach the toilet and/or washing facilities.	1	There is only one bathroom area meaning there is sharing between sexes. As a minimum requirement, male and female patients should have separate sleeping accommodation, separate toilets and separate washing facilities.' This minimum requirement is not met. The lay-out of the unit does not allow for different gender placement although we try to separate boys from girls and maintain constant supervision with regards to going to the loo and during bathing times. The patients thought supervised at all times share toilet and bathroom spaces. Children have separate bedrooms split according to self-identified gender. Due space limitation, toilets and washing facilities are not gender specific. Children do not go to the toilet and/or washing facilities unsupervised.
1.3.5	The unit has at least one bathroom/shower room per 3 young people.	3	There is one bathroom and one shower. As we only have capacity for 6 in patients this would meet the requirement for the 3:1 ratio described. There is one toilet for boys and one for girls. Sometimes there may be more than 3 boys or girls. One shower room and one bathroom for 6 patients so partially met. The TLC has one bathroom and one shower for the 6 patients. The ward has a 6 inpatient beds, it has a 1 bathroom and 1 shower room. Thus, the ward has at least one bathroom/shower room per 3 young people.

Chronological Order of Unit Standards for the Environment and Facilities (Category 1) Continued

	Unit Standards	Mode	Qualitative Reasoning
1.3.6	Every young person has an en-suite bathroom.	1	None of the rooms have en-suite available.
			No en suite facilities available.
			Bathroom is separate to bedroom.
			There is only 1 bathroom/shower per 6 kids.
			The bedroom is separated from bathroom and shower.
			The ward does not have en-suit bathrooms.
1.3.7	There are areas that may become single-sex lounges as required.	1	I'm not sure this would be particularly relevant in the TLC but there is no space for single sex lounges.
			Not available.
			Play can occur in separate room as needed but no specific designated areas.
			I work in a children's ward from ages 6 to 12.
			The general space at TLC presently has communal spaces only if the unit is full (6) the one patient sleeps in the TV/recreation area.
			Due to space limitations, the ward does not have designated areas that may become single-sex lounges as required.
1.3.8	The unit has a designated room for physical examination and minor medical procedures.	3	There is a clinic room available.
			Fully equipped clinic room and examination room.
			There is a clinic room that is fully equipped with an emergency trolley and other medical equipment needed for day to day management of minor ailments and injuries.
			The clinic room lack wall suctioning and oxygen. The physical examination can be conducted, but ant blood samples need to be transported to the main hospital RCWMCH.
			The ward has a designated clinic room that is used for physical examinations and minor medical procedures.

Chronological Order of Unit Standards for the Environment and Facilities (Category 1) Continued

	Unit Standards	Mode	Qualitative Reasoning
1.3.9	The unit has at least one quiet room other than young people's bedrooms.	2	There is a separate space where parents can meet with children though it is not a stand along room and people walk through it. Depending on who is visiting it is possible for this to happen. There are designated areas. There is a space created for visitors though it is not as secluded as one would have wanted. There is only one communal vesting room that can be used as a quiet, but only if one child receives visitors. The ward doesn't have a dedicated quiet room. However, multipurpose spaces are used for children to meet privately with visitors and a separate play area is available where children can engage in private activities and play.
1.3.10	There is a designated space for young people to receive visits from children, with appropriate facilities such as toys, books.	2	There is an area for children to meet parents. There are areas where visitors can be received but not solely designated for this purpose. The environment is not sophisticated enough to cater for all these fancy requirements. It was not designed for this purpose; apparently it was a medical ward/hospital. TLC doesn't have a child friendly visiting space. Although the ward has space limitations, the ward does have a designated space for children to receive visits from their family members.
1.3.11	Young people can make and receive telephone calls in private, where risk permits.	2	There is not a separate room for children to take calls. Calls are generally taken with a staff member present or close by. Phones are in public spaces or individual offices. There are no designated areas for phones. Children are supervised and are allowed 10 minutes of semi-private conversation as they tend to be emotional on the phone. The children can only receive call at night before 6 to 7pm for 10 minutes The calls need to be under supervision of the staff. Children are able to receive daily telephone calls in private, where risk permits. The ward does not have pay phones.

Chronological Order of Unit Standards for the Environment and Facilities (Category 1) Continued

Unit Standards		Mode	Qualitative Reasoning
1.3.12	All young people can access a plug socket for electronic devices such as mobile phones where risk permits.	1	Our policy is that children are not allowed phones on the ward. Not allowed phones or mobile devices in the ward. Electronic devices are not permitted as a standard. Not a practice at TLC. Mobile phones are not permitted in the ward as a risk management measure.
1.3.13	There is a safe place for young people to keep their property.	3	Each child has a separate space for their possessions. Children have cupboard space and drawer space but it is not locked nor is it private. There is a locker and a wardrobe to pack away clothes but expensive personal belongings are not accepted. The patients have defined spaces and their own lockers, but it's not lockable. Parents are encouraged to take patients valuables home for safe keeping. The unit has a secure space to store some items e.g., locked cabinet to store snacks, however bedside cabinets that usually store personal items such as books are not lockable.
1.3.14	There is a safe place for staff to keep their property.	3	Each staff member has a designated locker. Lockers with locks for staff. We do not accept personal belongings. Not all have lockers, awaiting stock. Ward nurses have a dedicated space which has lockers to store personal items; other multidisciplinary team members have offices which can be locked.
1.3.15	Young people are supported to access materials and facilities that are associated with specific cultural or spiritual practices, e.g. covered copies of faith books, access to a multi-faith room.	2	There is no multi-faith room available. If children requested to bring or brought a faith related book they would be allowed to and could keep it. No religious facilities available. Children of all religions are accommodated but this service can be expanded on. I think there is a room to improve diversity. Because we deal with younger children who are still under their parents guidance. This would only be done on request by patients No prayer rooms on site. The ward does not stock covered copies of faith books, but children may access these when requested. The ward does not have a designated multipurpose faith room.

Chronological Order of Unit Standards for the Environment and Facilities (Category 1) Continued

	Unit Standards	Mode	Qualitative Reasoning
1.3.16	Young people can wash and use the toilet in private, unless risk assessment deems they require constant observation.	3	There are private washing facilities. Dependent on risk children can wash in private. Staff do not observe when washing or going to the toilet unless clinical risk. Based on the outcome of the risk assessment, kids can be accompanied to the loo when the need arises. Even then, they are still given some space to go about their business in a comfortable manner. It is the standard practice in the ward for children to wash and use the toilet in private, unless risk assessment deems they require constant observation.
1.3.16	Staff members respect the patient's personal space, where risk permits e.g. by knocking and waiting before entering their bedroom.	3	There are private washing facilities. Dependent on risk children can wash in private. I have never seen staff knock before entering the bedroom. Being polite to each-other is one of TLC rules, therefore, this concept also represents being respectful to one another. The patients are at all times accompanied by a staff member, but allowed to be inside the toilet be in the toilet on their own if there isn't any risks involved. It is the standard practice in the ward for staff members respects the patient's personal space, unless risk assessment deems they require constant observation.
1.3.16	Laundry facilities are available.	2	There are private washing facilities. There is a big washing machine. No drying facilities. No specific laundry room. There is a washing machine available and the cleaning team is responsible for the children's laundry. Laundry room available, laundry are being done by the general staff, but no designated space for laundry to be dried e.g. washing lines or dryers. The ward has housekeeping staff that are responsible for doing laundry. The ward has an electric washing machine, but no tumble dryer or dedicated wash line area.
1.4.1	The team keeps medications in a secure place, in line with the organisation's medicine management policy.	3	Medications are kept securely. There is a dedicated medication cabinet in the clinic room. Medication is kept in the locked clinic room, in a medicine trolley under lock and key. Schedule 5 drugs are kept in a drug cupboard, under lock and key. Designated clinic room, medication stored and locked appropriately. The ward staff ensures that medication kept securely and in line with hospital policies and legislation.

Chronological Order of Unit Standards for the Environment and Facilities (Category 1) Continued

	Unit Standards	Mode	Qualitative Reasoning
1.4.2	Entrances and exits are designed to enable staff to see who is entering or leaving and if required CCTV is used to achieve this.	3	CCTV is in place and space is available to monitor entrance and exits The ward is not fit for purpose. CCTV has helped to improve observation, but this is not always monitored. CCTV Cameras are available and can be reviewed as needed. Security guards are on guard 24/7 and all entrances are operated by remote control. The courtyard has a high fence that makes it difficult for the kids to easily jump over it. Entrance and exits to TLC not manned by a specific security guard. The security guard is responsible for DCAP staff, patient and public's safety. The main entrance staff and public are often without a security. Due to the physical position of the entrance/exit doors and the use of CCTV monitoring system, staff are able to see who is entering and exiting the ward.
1.4.3	There are clear lines of sight to enable staff members to view young people. Measures are taken to address blind spots and ensure sightlines are not impeded, e.g. by using mirrors.	2	Cameras are in place to allow for monitoring This has only been achieved through the use of CCTV cameras which are not always monitored. The staff tries their utmost but infrastructure creates some blind spots. So staff has to move to keep children in sight. Staff members sit with the kids at all times and when they are asleep, we make use of the monitor which operates 24/7. When they go to the bathroom, a staff member accompanies them. The only method of viewing patients is staff presence and 24 hour CCTV monitoring. Although the ward is not purpose built, the presence of CCTV monitors assist with constant monitoring of patients.
1.4.4	Young people are cared for in the least restrictive environment possible, while ensuring appropriate levels of safety and promoting recovery.	3	Based on observation and experience on the ward, for the most part and where risk permits there are limited restriction on patient movement. Due to inexperienced staff restrictive settings such as time out and restraint may be used more frequently than is indicated. Staff with more experience and training is able to use de-escalation techniques more readily. All the employees are made aware from the first time they enter the unit that this is a therapeutic milieu and as such the standards of practice require that children be cared for in an environment that is loving and caring rather than cruel and punitive. The only areas for patients are the garden facility, communal TV/bedroom and visiting/recreation area.

Chronological Order of Unit Standards for the Environment and Facilities (Category 1) Continued

	Unit Standards	Mode	Qualitative Reasoning
1.5.1	Young people are consulted about changes to the Unit/unit environment.	3	Within reason and for the most part patients are informed of any changes and consulted where relevant Children are not consulted. All the kids are orientated to the programme and expectations, therefore, if there are any changes, they are informed in good time. They are also given an opportunity to share their feelings regarding the changes and what they feel could have been done differently. Amongst various factors, young people's opinions are taken into consideration when changes being planned and implemented e.g., holiday therapeutic programme.
1.5.2	Young people are able to personalise their bedrooms	3	Children can put up pictures, photo's, art work etc. Children are able to personalise the areas around their beds. They do not have single bedrooms. Shared rooms. Parents are given permission to bring any item that the children feel is of sentimental value to them, including photographs and bed line. Patients can personalize their bed spaces as there are no separate bedrooms. Patient are encourage to bring their own bedding, soft toys, but not past anything to the wall. Young people are able to personalise their bedroom areas, while respecting the space of other young person/s who share a bedroom with them.
1.6.1	A collective response to alarm calls and fire drills is agreed by the team and both are rehearsed 6 monthly.	1	To my recollection we have had one fire drill since I've been at the TLC the last five years There is no collective response. There have been two fire drills in 7 years so it is not done every 6 months. Even though each morning, staff members are allocated their responsibilities in case of an emergency, we haven't been exposed to a fire drill. A disaster plan is hung up on the wall in the hand-over room and visibly placed for everyone to see. Fire drills once in a while. Nursing staff are daily allocated to the disaster plan of TLC. The ward has an allocated health and safety rep. Fire drills are conducted regularly.

Chronological Order of Unit Standards for the Environment and Facilities (Category 1) Continued

	Unit Standards	Mode	Qualitative Reasoning
1.6.1	The Unit/unit has a mechanism for responding to low/unsafe staffing levels, when they fall below minimum agreed levels, including: A method for the team to report concerns about staffing levels; Access to additional staff members; An agreed contingency plan, such as the minor and temporary reduction of non-essential services.	3	The mechanism is to report this to management (ie Head of TLC, head of DCAP, hospital management). My experience is this is done on a regular basis. There is no stated method for reporting staffing concerns. There is a process for obtaining agency nursing staff when indicated. A duty rooster is drafted for the month and a nurse/patient ratio proportion is allocated each day for both day/night shifts. We also make use of agency nurses in cases of emergency. Staff levels are often measured, but post especially nursing posts are not filled immediately 2 vacant nursing specialty post for the last 18 months. Sometimes agency staff (additional nursing staff) arrive late due to a number of reasons including being unfamiliar with the geographical location of the unit, transport delays etc.
1.6.2	Emergency medical resuscitation equipment (crash bag), as required by Trust/organisation guidelines, is available within 3 minutes and its location is clearly identified.	3	As I understand there is an emergency trolley available that gets checked regularly - I'm unsure if it's clearly identified In clinic room. An emergency trolley is available and is fully functional. Same is locked in the clinic room and is checked daily for expired material and emergency drugs. Equipment is available from the clinic room, but transporting of patient to RCWMCH emergency unit can take hours due to delay in ambulance service. Completed emergency trolley track list forms. Nursing staff inspect the emergency trolley twice daily & complete track list forms accordingly.
1.6.3	The crash bag is maintained and checked weekly, and after each use.	2	I'm not sure how regularly it's checked Do not know what this is. It is checked regularly. It is checked daily but not used. It's part of the ward requirement according to national core standards. It can be used in an emergency. The crash bag is checked twice daily by the day and night nursing staff. Nursing staff inspect the emergency trolley twice daily & complete track list forms accordingly.

Chronological Order of Unit Standards for the Environment and Facilities (Category 1) Continued

	Unit Standards	Mode	Qualitative Reasoning
1.6.4	There is an alarm system in place (e.g. panic buttons) and this is easily accessible.	2	There is an alarm system in place. There are no panic buttons on the ward. No alarm system in place. I don't know where the panic buttons are. An alarm system is in place and a panic button though staff feels that the sound is not loud enough for all so as to draw attention in an emergency. No panic buttons. The nursing has a mobile panic button to alert security and others in case of an emergency. The ward is fitted with a security alarm system. The ward has two whistles that staff may use to alert other staff members or security personnel, when they need help.
1.6.5	Alarm systems/call buttons/personal alarms are available to young people and visitors, and instructions are given for their use.	1	There are no personal alarms etc. for patients. Not available. Probably because our patient capacity is very low at only 6 in-patients, whose movements can be monitored via the CCTV monitor with sometimes 1:1 supervision for high risk patients. Children in the ward are constantly monitored and supervised by nursing staff. Currently, they alert nursing staff verbally not with alarms or panic buttons etc.
1.6.6	An audit of environmental risk is conducted annually and a risk management strategy is agreed. *Guidance: This includes an audit of ligature points.*	2	There is an annual audit of the TLC but I'm not familiar if it includes environment risk. This is not done annually. Environmental risk assessment is occasionally done but on an ad hoc basis. A full risk assessment report is done on admission and weekly, followed by weekly administration meetings which look at possible admissions list and suitability for admission, staff patient ratio and ward security issues. Other issues discussed are about ward programme review, what worked and what can be changed or improved. National Core Standards and peer audits are conducted at least twice a year. They include standards that assess patient risk assessments and risk management; they don't specifically document ligature points. Ligature points inspections are done during infrastructure repairs inspections conducted by nursing area manager, TLC operational manager, maintenance manager and Division of Child and Adolescent Psychiatry clinical management.

Appendix D

Chronological Order of Unit Standards for Staffing and Training (Category 2)

	Unit Standards	Mode	Qualitative Reasoning
2.1.1	Where there are high dependency/high acuity cases (e.g. high levels of observation, use of seclusion, increased risk of violence or self-harm), there is a minimum ward staff to young person ratio of 1:1 to 3:1 for the most highly disturbed cases.	2	Duty roster would confirm this. While that is something that is aimed for in practice it is not always the case there us a 1:1 ratio when needed. Special request have to be made to nursing management to increase the staff patient ratio. Due to staffing shortages this is not always possible. Also agency staff are often used and they do not have the necessary skills to manage high risk patients. 1:1 is usually our max. Before we admit a high risk patient, we liaise with nursing management so that they can organize staff via the nursing agency to enforce the concept of 1:1 nursing and 24/7 nursing care. 1:1 nursing with a lot of persuasion to nursing management for extra staff. This is often supported with great reluctance from nursing management.. Nursing day-duty and night-duty roster. Sometimes due to staff shortage, less experienced or inexperienced (with respect to child psychiatry) agency/general hospital do nursing duty in the ward. In such instances, due to differing levels of experience 1:1 nursing may not be implemented effectively.
2.1.2	Where there are medium dependency (e.g. 10-minute checks, intensive support at meal times), there is a minimum ward staff to young person ratio of 1:2.	2	Duty roster would confirm this. For the most part this is true but not always the case. We aim to provide when indicated but as per previous question it is not always possible to employ agency staff at short notice nor is it possible to get adequately trained nursing staff. There is always someone allocated for the high risk patient at all times even before we start our ward routine. The ratio is only increased when patients are suicidal, aggressive or psychotic, The existing staff, 4 per shift will take care of the 6 patients irrespective of the patient needs. At many occasions the 6 patients were nursed by 3 nurses per shift and 2 nurses o night duty. At present the unit has one professional nurse with Advanced Psychiatric nursing skills This is excluding the operational manager. Where there are medium dependency (e.g. 10-minute checks, intensive support at meal times), there is a minimum ward staff to young person ratio of 1:2 with guidance from the multidisciplinary team.

Chronological Order of Unit Standards for Staffing and Training (Category 2) Continued

	Unit Standards	Mode	Qualitative Reasoning
2.1.3	Where young people are on general observations there is a ward staff to young person ratio of 1:3.	3	This is mostly the case, duty roster will confirm this. At night and over weekends there may be staff patient ratio of less than 1:3. There are 6 staff members per shift each day and this is according to national core standards. Our ward capacity is 6 inpatient in total. Adequate staff allocation makes it easier to delegate accordingly. The ratio is only increased when patients are suicidal, aggressive or psychotic, The existing staff, 4 per shift will take care of the 6 patients irrespective of the patient needs. At many occasions the 6 patients were nursed by 3 nurses per shift and 2 nurses on night duty. At present the unit has one professional nurse with Advanced Psychiatric nursing skills This is excluding the operational manager. Children on general observations are able to receive the minimum nursing staff to young person ratio of 1:3.
2.1.4	At night-time in a 6 bedded unit with general observations there is a minimum of two staff on duty, including one registered member of staff and access to additional support as appropriate.	3	Staffs are able to contract registrars and consultants as required. Duty roster will confirm this. Never less than 2 people on duty. Level of training and experience is however a concern. Staff allocation is adequate for the number of patients that we have. Our capacity is 6 and we have one nursing assistant and a registered nurse on duty on night shift and this number increases when we have a high-risk patient. Two nurses on night duty of which one is a registered nurse. Request need to be completed for additional staff which are often denied. According night-duty rosters, two nursing staff are always on duty - one professional nurse and one nursing assistant.

Chronological Order of Unit Standards for Staffing and Training (Category 2) Continued

	Unit Standards	Mode	Qualitative Reasoning
2.1.5	Senior nursing staff has the authority to arrange for additional staff to cover shifts in an emergency.	3	They have the authority to REQUEST extra staff. This request is not always met due to financial constraints or lack of appropriate agency staff. Nursing management has the authority to contact the nursing agencies as soon as they are notified of any shortages on the wards. Though senior staff has the authority to request additional staff the request isn't always met due to financial constraints. Agency staff are of send to the unit who had no exposure to psychiatry. The unit's nursing operational manager as the most senior nursing staff member has the authority to arrange for additional staff to cover shifts in an emergency.
2.1.6	The unit is staffed by permanent staff, and bank and agency staff are used only in exceptional circumstances e.g. in response to additional clinical need. *Guidance: A CAMHS inpatient unit is likely to have a problem with over-use of staff if more than 15% of staff are bank or agency staff during a week or if more than one member of staff on a shift are bank or agency. Bank and agency staff should not be used for more than two shifts in a day.*	3	I would think there have been a number of times where agency staff account for more than 15% of the nursing component (esp. if night duty if included). At the moment there are usually agency staffs on duty due to unfilled posts. Agency staff is only utilized in extreme circumstances, whereby 1:1 nursing with 24/7. Suicide watch is needed. The unit for the last two years has 2 open specialty nursing post. The unit is covered with 25% agency on day duty and 50% agency on night staff. DCAP staff establishment. All TLC multidisciplinary clinical team members are permanent staff. Currently, there are vacant nursing posts - thus, additional (agency) nurses work in the ward.

Chronological Order of Unit Standards for Staffing and Training (Category 2) Continued

	Unit Standards	Mode	Qualitative Reasoning
2.1.7	Where bank and agency staff is used, they are familiar with the unit. *Guidance: a maximum of 15% of staff during a week are unfamiliar (non-permanent or non-regular) bank or agency staff.*	2	The majority of staff are well familiar with the unit (often agency staff have worked at the TLC previously). Some agency staff have worked in the unit before and are therefore familiar with it. Others have never worked in the unit and are not familiar with it at all. Despite the fact that there is meant to be a policy for orientating agency staff to the unit, invariably this does not happen. I personally ask agency staff if they have had any orientation and invariably they answer no. We usually try to get agency that knows the unit. The operational manager, assisted by nursing management, liaises with the nursing agency and they both put in a request to use a consistent agency staff member for that area. The agency staff, on day duty, is not always familiar with unit and changes daily with constant. Constant supervision is needed. At present the agency staff on day duty is an ex staff permanent which contributes towards the stability. Night duty is often cover by a registered nurse who had no exposure to child psychiatry. Save, for 2 ex-TLC professional nurses who have retired (one retired 1 year ago, and another 2 months ago); agency nursing staff are not familiar with the unit.
2.1.8	Young people are able to access safe outdoor space every day where clinically appropriate.	2	There are some agency staff who work who have very limited experience with children or mental health. As per previous question some agency staff have worked in the unit before, whereas others have never worked in the unit and have enough experience. Again we try and ensure this but it's not always possible. It's not always easy to get consistent staff members as these people do freelance work as such they take anything at any time that they are needed. It's safe to say that the unit might not get the same agency nurse at the time of the crisis. The agency staff, on day duty, are not always familiar with unit and changes daily with constant. Constant supervision is needed. At present the agency staff on day duty is an ex staff permanent which contributes towards the stability. Night duty is often cover by a registered nurse who had no exposure to child psychiatry.

Chronological Order of Unit Standards for Staffing and Training (Category 2) Continued

	Unit Standards	Mode	Qualitative Reasoning
2.2.1	A typical unit with 6 beds includes a minimum of two registered nurses that have relevant child and young people experience, per day shift and one at night. At least one of which should have completed preceptorship.	2	Nursing at the TLC does have a mentoring system I'm aware of but I'm not familiar enough with nursing to know if we have a formal preceptorship system (that might be more formalised in the UK). Not always available due to high level of untrained nurses lacking child and adolescent psychiatry skills. A lot of experienced staff have retired and although the new staff have a psychiatry qualification, some of them do not hold an advanced course qualification. Management is busy and willing to send one nurse each year to college/ university to do the course. The unit has 4 staff member per shift on day. 3 registered nurses of which two are relevantly newly qualified, with no experience in child and adolescent psychiatry. One of the registered nurses is an agency sister (ex TLC sister). Night duty was cover with a relatively newly qualified sister and a nursing assistant. At times night duty has been covered by an ex sister from TLC with child and adolescent experience. Currently, TLC nursing staff have differing child psychiatry nursing experience. The majority have limited child psychiatry inpatient experience.
2.2.2	A typical unit with 6 beds includes 1 WTE ward manager (band 7+ or equivalent).	2	The nursing manager is not full time at the TLC, she is split with Outpatients as well. I don't think the band 7 is applicable (not sure the equivalent in South Africa). Operational manager covers ward and Out patients so is only 0.5 WTE in the ward. We do have an operational manager for each ward. The ward manager covers both OPD 50% and TLC 50%. TLC Nursing staff establishment and RCWMCH ODI (organisational development interventions). Since November 2017, the unit no longer has 1 WTE nursing operational manager. Currently, the Operational manager manages the inpatients and outpatients units.

Chronological Order of Unit Standards for Staffing and Training (Category 2) Continued

	Unit Standards	Mode	Qualitative Reasoning
2.3.1	A typical unit with 6 beds includes at least 1 WTE consultant child and adolescent psychiatrist input (which may be provided by two clinicians in a split post).	2	There is a Child and Adolescent Consultant but they are not full time at the TLC. Child psychiatrist is 0.5 WTE. We do have a child and adolescent consultant psychiatrist. The psychiatrist also covers consultation liaison services at RCWMCH. The unit also has a medical officer this post in the place of a senior registar. The senior registrars/psychiatrist post has been unstable as the occupants stayed in the posts for short periods then resigned. The unit has 0.5 WTE Child and Adolescent Psychiatrist input.
2.3.2	A unit with 6 beds includes at least 1 WTE nonconsultant Child and Adolescent Psychiatrist input.	2	This has changed at different times while I've been at the TLC. There is generally a senior/registrar or qualified Psychiatrist connected to the TLC however that person is never full time at the TLC. No post for this. Usually but currently very few consultants available. We do have senior registrar who also gives input during our clinical and admin meetings. A medical officer this post in the place of a senior registar. The senior registrars/psychiatrist post has been unstable as the occupants stayed in the posts for short periods then resigned. Since Feb 2019, the ward has 0.5 WTE non-consultant Child and Adolescent Psychiatrist input in a 6 months contract post. Previously, the ward had 0.5 WTE non-consultant Child and Adolescent Psychiatrist input from a sub-specialist Child and Adolescent registrars.
2.3.3	A typical unit with 6 beds includes at least 1 WTE clinical psychologist.	2	There is a psychologist but not full time at the TLC. Clinical psychologist is 0.5WTE We do have a resident clinical psychologist allocated to the unit. The clinical psychologist also has an OPD work load. The ward does not have a full time clinical psychologist. The Clinical Psychologist in the TLC also provides services at the DCAP Outpatients Unit.

Chronological Order of Unit Standards for Staffing and Training (Category 2) Continued

	Unit Standards	Mode	Qualitative Reasoning
2.3.4	A typical unit with 6beds includes at least 0.5 WTE Social Worker.	3	We do have a Social Worker assigned that covers TLC and OPU, which would qualify as 0.5. 0.5 WTE social worker is present on the ward. We do have a social worker allocated to the unit. The social worker also has an OPD work load. The TLC Social Worker does provide at 0.5 WTE Social Work input.
2.3.5	A typical unit with 6 places includes at least 0.5 WTE occupational therapist.	2	We do have an OT but they are only two days a week, hence only partially met. OT only spends about 8 hours per week in the ward. We do have an OT allocated to the unit. The occupational therapists stationed at RCWMCH, spend two afternoons per week at the unit. The TLC Occupational Therapist (OT) offers OT input 2 days a week, which is just under 0.5 WTE.
2.3.6	The unit has formal arrangements to ensure easy access to therapists trained in psychological interventions (e.g. CBT, child and adolescent psychotherapy, psychodynamic psychotherapy, MBT, DBT, IPT, EMDR) List is not exhaustive.	2	We have had some arrangements where access to specific intervention by experienced or qualified staffs are provided but it is limited. This is available through staffing history. Clinical psychologist provides some of these interventions. We do from time to time get visiting professional clinicians from local and abroad and sometimes they do consult with our kids for therapy. The unit can request assistance from the specialist, but there are no formal arrangements in place. When clinically indicated, TLC patients continue to see DCAP Outpatients therapist in order to ensure continuity of care. When required, arrangements to ensure easy access to therapists trained in psychological interventions (e.g. CBT, child and adolescent psychotherapy, psychodynamic psychotherapy, MBT, DBT, IPT, and EMDR) are made.

Chronological Order of Unit Standards for Staffing and Training (Category 2) Continued

	Unit Standards	Mode	Qualitative Reasoning
2.3.7	The unit has formal arrangements to ensure easy access to a dietician.	3	There is a fairly good arrangement with dietitian at the main hospital when needed. The unit can refer to a dietician employed by the hospital. Referral pathway is the same as for all wards and OPU services. A dietician is always available whenever the need arises. All that is needed is to phone and make an arrangement for her to come. No formal arrangement in place, but the unit can request assistance from the dietician at RCWMCH. As the ward is part of the RCWMCH it has access to the RCWMCH Dietetics Department. However, due to being offsite the RCWMCH, the dieticians have to drive out to TLC.
2.3.8	The unit has formal arrangements to ensure easy access to a speech and language therapist.	2	There is Speech Therapy at the main hospital but they only treat younger children as far as I'm aware. We have very limited contact with them. As per previous question, can refer to SALT at RCWMCH. However most SALT at RCWMCH does not see children who are attending school. Usually able to arrange but not always easy. The unit falls under Red Cross War Memorial Children's Hospital therefore children have easy access to any specialized care that they might need. No formal arrangement, but formal request can be submitted to RCWMCH. RCWMCH speech and language therapy department referral pathways. TLC Inpatients are assessed and managed as part of outpatient clinics.
2.3.9	The unit has formal arrangements to ensure provision of arts therapists e.g. drama therapy, music, art.	3	We have a regular art therapist who comes in weekly. In the past we've also had music therapy. There are formal arrangements for Art therapy, yoga, swimming and more recently music therapy. Children are exposed to as much stimulation as needed and we an advantage in that we are an academic institution and therefore in constant liaison with universities and colleges who are always willing to share their expertise. Children attend weekly Art therapy sessions. Music Therapy Intern was placed at in TLC in 2018; it will continue to be provided based on the availability of Music Therapy Interns, currently no intern is placed in the TLC.

Chronological Order of Unit Standards for Staffing and Training (Category 2) Continued

	Unit Standards	Mode	Qualitative Reasoning
2.3.10	A typical unit with 6 beds includes at least 0.5 WTE family therapist.	1	We do not have a trained family therapist assigned to the unit. The Social Worker and Psychologist take up some of that role. No trained family therapist on the ward. Clinical psychologist covers this service. Our social worker holds dual roles, and being a family therapist and attending to social issues is part of her job description. No family therapist. DCAP does not have a dedicated family therapist as part of its current staff establishment. Family therapy input is provided by clinical psychologists and broader family therapeutic work input in the inpatient unit is provided by the ward Social Worker, under the clinical supervision of the ward clinical psychologist.
2.3.11	There is a minimum of one qualified teacher to four students per lesson. Requires a teacher to pupil ratio of 1:4 or less, the presence of specialist nursing staff or the provision of a room for individual teaching.	2	Currently we only have four children in thee unit and one teacher, which would meet the required ratio but often this has not been the case when we have 5 or more children. Teacher pupil ratio is 1:6 if the ward is full. There is however a teaching assistant present at all times. Our ratio is 1:6; however, we have a classroom assistant available to assist with the school work. One teacher to 6 patients The ward has 1 full time teacher and 1 classroom assistant. At least 2 nursing staff members are present in the classroom.
2.3.12	Young people have access to teachers of specialist subjects e.g. language tutors.	1	This service is not available. Not available. Our teacher can generally cover the syllabus up to grade 7 level. The present teachers presently teachers the children main stream and special needs. Additional specialists teaching input is arranged only when indicated, such specialists are not part of the Red Cross Hospital Primary school staff compliment.

Chronological Order of Unit Standards for Staffing and Training (Category 2) Continued

	Unit Standards	Mode	Qualitative Reasoning
2.3.13	Young people have access to other education professionals as required *Guidance: Career advisors, educational psychologists etc.*	2	There are some links to the dept. of education which allow for these services. They can be referred to WCED educational psychologists. There are usually long waiting lists. We usually link with outside professionals. TLC has access to career guidance teachers and educational psychologist on request. TLC children have access to a special education advisor and educational psychologist from the Western Cape Education Department.
2.3.14	A typical unit with 6 beds includes 1 WTE administrator (band 3 or above or local equivalent).	2	We have a part time when admin person assigned (again, I don't know the band 3 equivalent). There is not 1WTE administrator for the ward. There is a ward clerk who performs some of the administrator duties but she is not full time in the ward. Admin staff shared with outpatients. The TLC Administrator covers TLC until 13h00 daily then performs and OPD function until 4pm. RCWMCH Administration Department staff establishment and DCAP staff establishment - Admin clerks. The ward has clerical input 4 mornings a week, which is less than 1 WTE.
2.3.15	Unit staff have input from a pharmacist.	2	This would be better answered by the medical doctors and nurses. There is contact with Pharmacy as needed. They can access the hospital pharmacist by telephone or email. Pharmacy not on site but provides telephonic gatekeeping and all meds are issued via pharmacy. Pharmacist liaises with staff members including prescribing doctors if there are any discrepancies in the child's treatment. TLC patient medications are prepared by The RCWMCH pharmacist. Nursing staff drops and collects medication from RCWMCH at least twice a week.

Chronological Order of Unit Standards for Staffing and Training (Category 2) Continued

	Unit Standards	Mode	Qualitative Reasoning
2.3.16	There is an identified duty doctor available at all times to attend the ward/unit, including out of hours. The doctor can: • Attend the ward/unit within 30 minutes in the event of a psychiatric emergency; • Attend the ward/unit within 1 hour during normal working hours; • Attend the ward/unit within 4 hours when out of hours.	3	This would be better answered by the doctors around the precise timing but my understanding is that they would be able to attend in those time periods as needed. There is a Dr. on call throughout the day and night who should be able to meet the time frames required. An on-call list is issued every month. Registrar on call roster is being used, the registrar or consultant are available, but not always within 30 minutes as they are often off site, at a clinic or consulting. RCWMCH Child and Adolescent Psychiatry On-call roster, DCAP Medical and Psychiatric emergency SOP.
2.3.17	There has been a review of the staff capacity and skill mix of the team within the past 12 months. This is to identify any gaps in the team and to develop a balanced workforce which meets the needs of the ward/unit.	1	We do have an annual review which does look at staff levels. The review is currently being undertaken. Every unit has a specific number of professionals required and the appropriate qualifications for each. Ours is a specialty unit and staffing is managed as such. Staff capacity is discussed during the review meetings. A formal skills matrix has not been conducted, high turn-over of staff makes it difficult to get a realistic reflection of the skills mix, as this fluctuates with attribution and entry of new staff.
2.3.17	Young people returning from ward leave are able to access a bed on their ward within 6 hours.	3	Children who have been previously admitted to the ward and returning from leave would always have a bed available. This is recorded in inpatient files and nursing notes. Beds are kept open when patients go on ward leave so their bed is always available. Beds are kept open for them. Beds are always available until a child is discharged. The patients' return to their same bed after weekend leave as their beds is not used for other patients over the weekend. TLC inpatient statistics. Children returning from weekend or school holidays home leave are able to access their beds upon return to the ward. The ward has a TLC weekend emergencies SOP, should children need to return to the ward prematurely.

Chronological Order of Unit Standards for Staffing and Training (Category 2) Continued

	Unit Standards	Mode	Qualitative Reasoning
2.3.17	Staff members who administer medications have been assessed as competent to do so. Assessment is done using a competency-based tool.	3	I do not believe that staff who administer medication have been assessed using a competency based tool. They have been assessed by operational manager but not sure if quality control tool is used. They are trained at a credible academic institution. The medication is only administered by professional nurses and no other category of nursing staff. RCWMCH Nursing department- Medication management policies and procedures. Professional nurses manage and administer medication in the ward as they are specifically training to do so.
2.3.17	Staff members can access leadership and management training appropriate to their role and specialty.	3	Staffs have the opportunity to go training courses but do not always have the opportunity to do so. They are trained at an academic institution. Staff has to apply for special leave via the skills development department at RCWMCH. Requests are often denied due operational requirements or courses not being registered. RCWMCH annual individual staff development plans. All staff completes annual individual staff development plans which ensure access to leadership and management training appropriate to their role and specialty.
2.3.17	The team has received training in reflective practice.	2	I'm not aware that there has been a specific course solely focusing on reflective practice by many of the trainings has looked at this ethos or principles embedded within. Training schedules would shed some light on this. No training in reflective practice has taken place. Clinical psychologist has been providing this type of teaching. They are trained at an academic institution.. Some team members received training in reflective practice e.g., Psychologist and Psychiatrists. However, in-service training in reflective practice has not been accessed by all staff. That being said, all staff members receive clinical supervision in order to facilitate reflective practice at a practical level.

Chronological Order of Unit Standards for Staffing and Training (Category 2) Continued

	Unit Standards	Mode	Qualitative Reasoning
2.4.1	There are written documents that specify professional, organisational and line management responsibilities.	2	There have been multiple changes at the TLC making defining/separating of roles challenging. Check job descriptions. Line management responsibilities are clear. Professional staff report to their own professional grouping which can sometimes lead to confusion. There are no clear guidelines for distributive responsibility. Staffs are clear and most have set job descriptions and responsibilities. Not sure where these documents are kept. Each employee gets a job description document before they start their duties. Nursing staff are clear about their job descriptions/responsibilities, but often not confidents in performing their duties within child and adolescent psychiatry. Available through DCAP Organogram and Job descriptions.
2.4.2	The MDT attends business meetings that are held at least monthly.	3	I'm assuming in this case a business meeting is our equivalent of an admin meeting. These are held weekly. These happen weekly. We have different meetings each week, such as, ward rounds; goals and strategy meeting; case presentation; parent feedback meeting; and academic presentation meeting. TLC has weekly ward rounds which are attended by members of each discipline. TLC staff attend weekly admin meetings to discussions operational, day-to-day ward business issues.
2.4.3	In a typical 6 bedded unit, there is time scheduled in staff rotas to allow 30 minute handover sessions between shifts.	3	There is an assigned time for hand over between nursing/doctor according to TLC schedule. These take place in the mornings. I am not sure that there are 30 minute handovers in the evenings. Staff plan for handover. We have a handover room and it is used for such. Nursing handover occurs between shifts, often lasting more than 30 minutes. TLC daily mornings and evening nursing handover meetings. Weekdays, morning meetings between ward nurses and ward doctor.

Chronological Order of Unit Standards for Staffing and Training (Category 2) Continued

	Unit Standards	Mode	Qualitative Reasoning
2.4.4	The team has integrated records of the young people which can be accessed by all clinical staff.	3	We have in-patient folders which can be accessed by team members as needed.
			Nursing notes are kept separately and are not integrated into the files.
			Clinical folders are multidisciplinary input.
			The daily nursing notes is not included in the clinical notes and only filed within the clinical folder after discharge. The nursing notes are kept in the nurse' station until patients discharge for easy access by the nursing team.
			TLC Clinical folders have integrated clinical notes from the MDT organised chronological by profession. The current TLC clinical note keeping system is in compliance with National Core Standards Audits - MDT Clinical notes standards.
2.4.5	The unit has a whistleblowing policy and staff members are able to raise concerns without prejudicing their position.	1	I'm not familiar with a whistleblowing procedure or policy.
			None exists as far as I am aware.
			I think it exists but not sure if all staff know exact policy.
			Weekly admin meetings are held for such matters and individuals have an opportunity of going for supervision to share about their grievances and how this impacts on their work.
			All staff is aware of incidences Concerns are brought to the multidisciplinary team after discussion. Individual concerns are being with dealt separately.
			Local policies and procedures with relevant legislation. The ward complies with hospital policies and procedures regarding whistleblowing, it does not have a whistleblowing policy specific to the TLC setting.

Chronological Order of Unit Standards for Staffing and Training (Category 2) Continued

	Unit Standards	Mode	Qualitative Reasoning
2.4.6	The ward/unit actively supports staff health and well-being. *Guidance: For example, providing access to support services, monitoring staff sickness and burnout, assessing and improving morale, monitoring turnover, reviewing feedback from exit reports and taking action where needed.*	2	There is access to support through ICAS (as there is for all government staff). However, given the high rate of burnout I'm not sure that we are always able to support staff sufficiently in this area. There is access to staff wellness and staff support but I am not sure that all staff are aware of these and would access them if needed. The team strives to support one another by ethos but not clear on formal details. Nursing management does not really care much about staff wellness; they have an autocratic approach in their style of management. Staff are informed of wellness days, but often doesn't attend as it's off site at RCWMCH or the ward is too busy. Staff is aware of ICAS, but reluctant to access it for mental health care. TLC has well and team building once a term (poorly attended). The unit doesn't feedback re: exit reports. RCWMCH Staff wellness clinic referral pathways and programs. Referral to ICAS employment wellness programme. TLC termly staff team building schedule. Due to TLC clinical and nursing staff falling under two different line management structures, feedback on staff morale and exit interviews is not shared consistently.
2.4.7	The team has protected time for team-building and discussing service development at least once a year.	3	We have regular (quarterly) team building activities and an annual review meeting. Team building and service development takes place at least twice a year. Team building is held monthly and the review meeting is held yearly. Team building time is allocated, but poorly attended.
2.4.8	Staff members are able to take breaks during their shift that comply with the European Working Time Directive (or local equivalent). *NB: With the European Working Time Directive you can't work more than 48 hours a week on average - normally averaged over 17 weeks. This law is sometimes called the 'working time directive' or 'working time regulations'. You can choose to work more by opting out of the 48-hour week. If you're under 18, you can't work more than 8 hours a day or 40 hours a week.*	1	I'm not sure what set working hours are for doctors and nurses. I am not sure what the staffing requirements are for all staff. Not sure of we adhere to European guidelines. I think our staffs routinely work longer hours. Especially nursing. Work a 40 hour week. Nursing staff work a 40 hour week 3 x (7 to 7) = 11 with 1 hour lunch and 2x half hour tea per shift + 1 x 7hrs (7 to 13h00). Staff often work during lunch and tea breaks during an emergency and are sometimes not able to take long enough breaks within their shifts. Basic conditions of employment regulations.

Chronological Order of Unit Standards for Staffing and Training (Category 2) Continued

	Unit Standards	Mode	Qualitative Reasoning
2.5.1	All qualified staff receives at least 5 days training and continuing professional development activities per year in line with their professional body, in addition to mandatory training.	3	This would be the case for me, but I'm not sure if it is the same nursing in particular. Staffs have development plans. Not all staff access training opportunities. For example the nurses do not always attend Friday academic seminars. Although there are staffs development plans in place they are not always met. There is not enough emphasis on staff development and meeting staff training needs particularly for the nurses. Good support but less clear career development paths. All new employees are allocated a mentor for at least a period of 6/12 or until one is confident about what the work entails. Academic DCAP training programme as available weekly (Fridays). Staff can apply through skills development RCWMC to attend other appropriate training programmes. Annual individual staff development plans, in-service training and continuing professional development activities.
2.5.2	The organisation has a budget for staff training and development.	3	This is a set budget allocated for training for every Gov. employee. HR could provide specific details of this. All staff can access training funds to a maximum of R10000 per annum accordingly RCWMCH Policy. Each staff member can attend training to the value of R10,000 via Skills development RCWMCH Annual individual staff development plans, RCWMCH Staff Development office policies and procedures.
2.6.1	The team receives training, consistent with their roles, on risk assessment and risk management. This is refreshed in accordance with local guidelines. This includes, but is not limited to, training on: • Safeguarding vulnerable adults and children; • Assessing and managing suicide risk and self-harm; • Prevention and management of aggression and violence.	2	There is regular training that takes place; it could be that there is more regular or frequent training in the area. Check training schedules. This should be ongoing and regular. Not all staff have been trained in risk management. there is ongoing training in managing the aggressive patient. Training is done. Unsure if all topics are covered. Each category of staff receives training according to their level of qualification. New trends/ policies are discussed during academic case presentations DCAP academic programme. Psychiatry professional training, Timian 3-day course and weekly practice sessions, in-service training.

Chronological Order of Unit Standards for Staffing and Training (Category 2) Continued

	Unit Standards	Mode	Qualitative Reasoning
2.6.2	Care co-ordination including transfer of care.	2	I am not sure what this is asking. Not all care co-ordination within mental health and it other agencies such as DSD and DOE takes place appropriately. We use a caring approach which is co-ordinated and transferred to the patients. Not sure what is expected. Termly case presentations meetings are held in the TLC, where all relevant clinical service providers (pre-admission and post-discharge), Western Cape Education Department educational psychologists and relevant social workers (if indicated) are invited to discuss management planning. School bridging meetings are held pre-discharge between TLC clinical psychologist, TLC teacher and relevant school personnel to coordinate school bridging. Discharge meetings are held to discuss transfer of care.
2.6.3	Managing relationships and boundaries between young people and staff, including appropriate touch.	2	There are discussion about patients and some trainings that look at this areas (e.g. Timian training) - but not a specific course that focuses on this area. I am not aware that this is regularly addressed with staff or formalised in any way. The environment is guided by the behavior modification approach, therefore, 'staying in your space' and 'no inappropriate touching' is one of the many behavioural rules that everyone abides by. Regularly discussed during nursing meeting and patients handover meeting especially in view of new staff and very challenging patients. Behaviour management policy, Timian training and CCTV monitoring.
2.6.4	Observation and engagement.	3	Part of the treatment approach is just about observing mood and behavior and how the child interacts with others. This helps in how the treatment approach is going to be managed. Ongoing constantly discussed amongst staff regarding patients' behavior, interventions and management. TLC therapeutic programme, TLC nursing care plans, Psychiatric reviews and weekly ward rounds. Individual psychotherapy (when indicated) and parenting input.

Chronological Order of Unit Standards for Staffing and Training (Category 2) Continued

	Unit Standards	Mode	Qualitative Reasoning
2.6.5	The use of legal frameworks, such as the Mental Health Act (or equivalent) and the Mental Capacity Act (or equivalent).	3	The relevant acts are used by staff appropriately and as needed for individual patients. Children's Act. MHCA does not apply to under 13s. The mental Care Act is there to protect and guide the practitioner and also serves as the guideline in terms of rights of the patients and also under which circumstances should certain rules and regulations be applied. The Mental Health Care Act No 17 of 2002 and The Child Care Act No 38 of 2005 governs our work. The principles and implications of the acts are regularly discussed. Children's Act No 38 of 2005. The ward admits children between ages 6 - 12 years old in accordance with relevant legislative framework.
2.6.6	All qualified nursing and medical staff that administer rapid tranquillisation need to have done Intermediate Life Support training.	2	We don't routinely do rapid sedation. So most senior staff, usually doctor would administer if absolutely needed. Life support training is available each year and staff members are sent for training when their time is due. All nursing staff except for one who is schedules to attend in June has attended Basic Life support. Basic life support and advanced pediatric life support courses. TLC nursing and medical staff are either have updated training or are scheduled train or update training.
2.6.7	All other staff have done Basic Life Support training.	2	I haven't done the training and aside from doctors and nurses not sure other staff have either. Not all staff have had basic life support training. It is done in turns and nursing management always sends a list of candidates due whenever the time arises. According my knowledge only medical and nursing have attended. Professional training of Non-medical/nursing staff does not include basic life support, thus additional basic life support training certification would be evidence. Non-medical/nursing staff are not all trained in basic life support.

Chronological Order of Unit Standards for Staffing and Training (Category 2) Continued

	Unit Standards	Mode	Qualitative Reasoning
2.6.8	Shared in-house multi-disciplinary team training, education and practice development activities occur on the ward/unit at least every 3 months. *Guidance: This includes discussion of evidence based treatment, for example, NICE guidelines.*	1	I am including DCAP here (rather than just TLC) as in-house, in which case we have regular exposure through the weekly academic meetings. Although these are not always focused on NICE guidelines or evidence based treatments. Only Timian training is done on a regular basis as part of shared in house training. No regular training on updates of NICE guideline etc. Training should happen every school term, but this is not always possible as it depends on the availability of staff to facilitate this and also the kind of patients that we have. Lately, nursing management demands that staff works at a general hospital (main hospital) when there are no kids on the unit. Not being done. DCAP Friday academic meetings, TLC in-service training schedule. However, due to scheduling of off-duties - consistent attendance of Friday academic meetings is often difficult for inpatient nursing staff.
2.6.9	Non clinical staff have received mental health awareness training *Guidance: This includes teachers, administrators and domestic staff.*	2	SPMS and development programmes for staff members. The teacher does have access to that training. I don't think domestic staff and admin do though. Non clinical staffs do not get MH awareness training. The teacher has some MH training but this is an ad hoc and not clearly defined. Not being done. TLC Teacher - WCED and TLC in-service training. DCAP Friday academic meetings. Admin clerks attend courses which may cover aspects of mental health awareness; however, I'm not aware of a specific mental health awareness course - the operational manager may be able to provide better clarity.

Chronological Order of Unit Standards for Staffing and Training (Category 2) Continued

	Unit Standards	Mode	Qualitative Reasoning
2.7.1	Staff members have access to study facilities (including books and journals on site or online) and time to support relevant research and academic activity.	2	Internet connection and access to journals limited to non-UCT affiliated staff members. While the clinical staffs do have access and more dedicated time, I don't think nursing has as much opportunity as regards access and time. Some staff members e.g. the psychologist and psychiatrist have access to this through joint appointments with UCT. Not available to all staff. Limited resources and limited time. Online material is available and ongoing training in the form of weekly Timian training and weekly supervision by our highly qualified psychologist. All staff can access the resource room in OPD. DCAP Staff resource library (onsite) has books and journals. Online access to journals and books is available to staff jointly employed by the University of Cape Town. Not all staff is able to access online journals and books.
2.7.2	Staff members receive an induction programme specific to the ward/unit that covers: • The purpose of the ward/unit; • The team's clinical approach; • The roles and responsibilities of staff members; • The importance of family and carers; • Care pathways with other services. *Guidance: This induction should be over and above the mandatory Trust or organisation-wide induction programme*	2	There is an orientation folder and an undertaking that this be followed. It does not have all of those details (e.g. there isn't a section on the importance of family and parents) and it is not always followed. There is limited induction taking place. It does not cover all the areas covered. A mentor is allocated for a period of at least 6/12 to guide and teach the staff members about what is expected of him/her. General induction to the ward hen induction by the specific discipline. RCWMCH Induction course for permanent employees. TLC orientation policy and procedures. TLC Orientation file. Consistent monitoring of the effective implementation of the TLC orientation process according to differing needs of various professional fields remains a challenge.

Chronological Order of Unit Standards for Staffing and Training (Category 2) Continued

	Unit Standards	Mode	Qualitative Reasoning
2.7.3	Bank and agency staff receives an induction based on an agreed list of core competencies. *Guidance: This should include arrangements for shadowing colleagues on the team; jointly working with a more experienced colleague; being observed and receiving enhanced supervision until core competencies have been assessed as met.*	2	There is support given to agency staff through the orientation manual but I don't think it is always implemented. The induction for agency staff is inadequate and core competencies are NEVER assessed. Induction happens on the day of the shift cover. No shadowing day as the unit doesn't which nurse have been allocated to the unit. Orientation of agency staff remains difficult to implement as they usually come to the ward when there are staff shortages, thusly, there usually isn't enough time to do orientation.
2.7.4	Young people, carers and staff members are involved in devising and delivering training face-to-face.	1	Over the years staff members have been involved in devising and implementing training but young people are not involved in that, principally because of the age group of our patient population. Young people and carers are not involved in training. Not being done. Not currently done. Question does not clearly define whom the face-to-face training is for.
2.8.1	All clinical staff members receive individual clinical supervision at least monthly, or as otherwise specified by their professional body.	3	Individual staff diaries and schedules. To my knowledge all clinical staff have supervision. In theory this is meant to be the case. In practice often the most junior staff has least access to supervision. There is no system in place for measuring attendance at ongoing supervision or the outputs. Supervision is held weekly by our highly qualified clinical psychologist. Nursing staff receive supervision from the clinical psychologist on a Wednesday 09h30 to 10h30 and 10h30 to 11h30. All TLC staff receive clinical supervision according to schedules.
2.8.2	All staff members receive monthly line management supervision, proportionate to their roles.	3	Individual staff schedules. This is often included in supervision. Again to my knowledge this is the case. Weekly admin meeting. Happens daily to empower the new registered nurses. Meetings are also held with the enrolled nursing assistance. Clinical staff meets with line managers at least once a month. Nursing staff line management meetings are held according to nursing management protocols.

Chronological Order of Unit Standards for Staffing and Training (Category 2) Continued

	Unit Standards	Mode	Qualitative Reasoning
2.8.3	All supervisors have received specific training to provide supervision. This training is refreshed in line with local guidance.	1	While supervisors are supported in their role as supervisors I'm not aware that there has been specific training in how to supervise. No supervision training is provided. I think most supervisors have. Not done. Some supervisors received training as part of their professional training, while others have scheduled formal in-service training (on the job training).
2.8.4	Staff members, young people and carers who are affected by a serious incident are offered a debrief within 24 hours and post incident support.	2	There are attempts to do this but is not always done consistently. Debriefing does not always take place within 24 hours. Not all staff get debriefing due to shift changes etc. A 'worry' group is held to give both kids and staff members to address issues of concern. Incident reports are being completed; staff supported and followed up at staff health RCWMCH. Staff is also encouraged to make use of ICAS. Full Patients receive immediate physical attention and support. Statements are not always completed within the first 24 hours. Occupational health and safety policies and procedures, adverse incidents management standard operating procedure. ICAS Employees Wellness Programme - referral pathways. Patients, carers and staff are managed and referred according to local policies and procedures after adverse incidents.
2.8.5	Staff members have access to reflective practice groups.	2	There was a period where that happened but not currently. A feeling group is held weekly and staff members sit in, co-facilitate and participate in the session. Does it mean support group? Staff can access the ICAS Employer support service for individual support = 6 free sessions, but group support is only on request from the department where the specific group works. Following adverse incidents, staff are offered participation in group reflective process facilitated by an external (ICAS facilitated) group facilitator. However, these are not routinely held i.e., without an adverse incident having occurred.

Chronological Order of Unit Standards for Staffing and Training (Category 2) Continued

	Unit Standards	Mode	Qualitative Reasoning
2.8.6	Staff members in training and newly qualified staff members are offered weekly supervision.	2	Individual nurses do not receive weekly supervision. They are not offered weekly supervision. Alternate week supervision is offered and not all staff members attend due to shift changes. Weekly supervisions are held. Supervision every second week due to shift work as staff are day off second Wednesday when supervision occurs. Clinical supervision meeting schedules according to various professional fields. Although, scheduled weekly; due to off-duty scheduling issues, consistent weekly attendance of supervision by individual nurses remains a challenge.
2.8.7	All newly qualified staff members are allocated a preceptor to oversee their transition onto the ward/unit. *Guidance: This should be offered to recently graduated students, those returning to practice, those entering a new specialism and overseas prepared practitioners who have satisfied the requirements of, and are registered with, their regulatory body. Seehttp://www.rcn.org.uk/__data/assets/pdf_file/0010/307756/Preceptorship_framework.pdf for more practical advice.*	3	As I understand each nurse is assigned a mentor (I'm assuming this is what is meant by preceptor). Most staff has a manager who support them as they transition. In theory this should happen but very often it does not. The mentors are not always available and the mentees are not always receptive to mentoring. There is something in the system that prevents appropriate and sensitive mentoring to take place. A mentor is supplied to assist for a period of 6/12. Staff is allocated a mentor over and above supervision. Clinical staff are allocated according to professional fields. Nursing staff are also allocated mentors.
2.8.8	All staff members receive an annual appraisal and personal development planning (or equivalent).	3	There is an annual performance and development plan and a quarterly appraisal plan. SPMS is a job requirement. I think so. HR also requires this. SPMS is done 6/12. This is being done via the SPMS Staff Performance Management System. Western Cape Department of Health Annual appraisal system - quarterly reviews. All staff have annual appraisals.

Chronological Order of Unit Standards for Staffing and Training (Category 2) Continued

	Unit Standards	Mode	Qualitative Reasoning
2.9.1	Young people are involved in and influence the recruitment of unit staff.	1	By young people I'm assuming this means in-patients. There is some attempt to get feedback on their experience though this is not formalised. There is not a formal way for in-patients to be involved in the recruitment of staff. Does not happen. Patients are under 13 and usually don't participate. Not being done. No evidence. This standard is not met.
2.9.2	Human resources staff ensures that all unit staff, including temporary staff, undergoes a Disclosure and Barring Service (DBS) check (or local equivalent) and are checked against the Protection of Children Act (POCA) register before appointment. Ongoing monitoring of this is carried out every three years.	2	Hospital HR Policy. As I understand all staff members are required to go through police clearance checks. All staff have police checks prior to being appointed to the job. These are not monitored every 3 years. I think this is routinely done. All staff need to get police clearance but I am not sure re: checking if staff names appear on the sexual offenders' register. Human Resources conduct police clearance verification/checks for all Department of Health Employed staff.
2.9.3	Human resources staff ensure that all staff with a professional regulatory body are checked for appropriate registration on recruitment and again at renewal date.	3	Annual reminders to give in relevant documents are sent by HR based on their policy. This is meant to happen but I am not sure whether HR follows up on this. Nursing cannot practice if they haven't renewed their registration at the South African Nursing Agency. Proof of professional regulatory body registration is required as part of the recruitment and selection process. Subsequent to that proof of annual professional regulatory body registration is required. All Department of Health employed staff are required to meet the above requirements.

Appendix E

Chorological Order of Unit Standards for Access, Admission and Discharge (Category 3)

	Unit Standards	Mode	Qualitative Reasoning
3.1.1	Clear information is made available, in paper and/or electronic format, to the young people, carers and healthcare practitioners on: • A simple description of the ward/unit and its purpose; • Admission criteria; • Clinical pathways describing access and discharge; • Main interventions and treatments available; • Contact details for the ward/unit and hospital.	2	This information pack is given to patients/parents in the information pack. Parents and children are given information sheets when attending for an inpatient assessment. Not all the requirements mentioned are on the information sheet. Information is given to parents and children are orientated to the unit on admission. This is given with the first pre-assessment appointment. For emergency admissions on the day of admission. Children and carers are given the information pack as standard practice.
3.1.2	Unplanned admissions need an initial planning meeting with local services within five working days of admission.	1	I'm not sure what is considered 'local services' in this case. If it includes referral agents then that would generally be the case. Very few unplanned admissions and meeting with referring agent does not take place within 5 days. It's being done. Treatment planning discussions are held at the initial MDT ward round discussions which are held weekly i.e., within 5 days of admission. Local services have not always been able to attend.
3.1.3	Senior clinical staff members make decisions about the young person's admission or transfer. They can refuse to accept young people if they fear that the mix will compromise safety and/or therapeutic activity. *Guidance: Senior clinical staff members include the ward/unit manager or nurse in charge*	3	Senior clinical staff routinely makes decisions about inpatient admission or discharge. This happens frequently. A comprehensive discussion is held by the MDT and two sessional interviews with the family to check suitability are held before a child can be admitted to the unit. In-dept clinical discussions with are being re the suitability and fit of patient within the patient cliental and programme. TLC referral pathway document and clinical notes. Clinical head with nursing and MDT input makes decisions about the children's admissions or transfers from the TLC.

Chorological Order of Unit Standards for Access, Admission and Discharge (Category 3) Continued

	Unit Standards	Mode	Qualitative Reasoning
3.1.4	The unit formally records all referrals with respect to race, gender, home area and disability, and this is reviewed annually.	3	Annual review does, I believe, look at most of these areas. There are records but race is not recorded and this is not reviewed annually. As mentioned, clinical head with nursing and MDT input makes decisions about the children's admissions or transfers from the TLC.
3.2.1	Young people at severe risk can be admitted as emergencies (i.e. within 24 hours) including out of hours. Units that fail to meet have a plan in place to deal with emergency referrals.	2	Arrangements are made with the main hospital and SOP. The only proviso is when the ward is full then, obviously emergency patients cannot be taken in. Children and adolescents can be admitted via district hospitals as emergencies. There are often not appropriate wards for them, e.g. adolescents placed in adult wards. Children placed in children's medical wards. They are very rarely admitted to the TLC ward as emergencies and if so are never admitted after hours. Emergencies are admitted to the main hospital and a senior registrar on call attends to these. Decision is made by the consultant and the child is discussed further with the MDT. Patients are not being admitted to the TLC afterhours, but instead to the emergency services at RCWMCH. Full assessment and in-depth discussions by the multi-disciplinary team and if the patient is suitable for TLC, transfer will occur the next day.
3.2.2	There is a clear process in place for handling situations where agreed bed occupancy levels need to be exceeded.	3	My understanding is that there is a process in place for when we are full. No process in place. We have never exceeded our bed capacity of 6. Extra patients are given the day patient status. This is done via the medical manager by the HOD, but needs a lot discussion and motivations. When the ward is full, patients who require emergency care are admitted in other settings.
3.2.3	There is a system in place to monitor and address delays in admission and treatment which is reviewed annually.	3	This is reviewed on an on-going basis. There is no system in place to monitor delays in admission. None in place. At TLC review meetings referral, preadmission assessments and admissions are reviewed - in that way delays in admissions and treatment are tracked on an annual basis.

Chorological Order of Unit Standards for Access, Admission and Discharge (Category 3) Continued

	Unit Standards	Mode	Qualitative Reasoning
3.2.4	The aims of the treatment are discussed with the young person and others involved in care.	3	Children have the aims of admission explained to them, and these continue to be discussed with them throughout their admission. The children are often unaware of the aims of the admission. Parents and the child are always made aware of their treatment and the changes made The senior registrar or the consultant are the appropriate clinicians for this role. Part of the management plan. This is done routinely at different time points including at admission, case manager and contact nurse discussions with the child and/ or carer, parent/carer feedback meetings and discharge planning meetings.
3.2.5	Young people have a comprehensive assessment which is started on the day of admission and completed within four weeks. This involves the multi-disciplinary team and includes young people's: Mental health and medication; Psychosocial needs; Strengths and weaknesses; and Views and personal goals	3	Through patient notes. Certainly that is what is aimed for, although practicalities mean it cannot always be implemented (e.g. parents are not available for history taking sessions). Comprehensive assessment is not completed within four weeks. There are often delays in interviewing the families and in obtaining multi-agency input. This is an important area which needs addressing as children often stay in the ward for longer than necessary. Assessment starts even before admission. The patient and family are seen for 2 assessment interviews before a decision is made whether to admit or not. The focus of the treatment plan including management strategy is discussed comprehensively by the MDT so that on admission everyone is aware of what is expected from them. MDT clinical notes and nursing process notes, strength and difficulties questionnaires. This is done as standard practice.
3.2.6	All assessments are documented, signed/validated (electronic records) and dated by the assessing practitioner.	3	For the most part this is the case, although these are mostly all paper notes (not electronically done). They are not always timelessly signed and dated although this is the objective. Every information given by the family including the plan of action/management plan is always documented but, not electronically and is kept in a safe environment. Not all the documentation as electronically. MDT Clinical notes and nursing process notes. Done as standard practice.

Chorological Order of Unit Standards for Access, Admission and Discharge (Category 3) Continued

	Unit Standards	Mode	Qualitative Reasoning
3.2.7	There is a documented admission meeting within one week of the young person's admission. *Guidance: This could take the form of a ward round meeting or a Care Programme Approach meeting (or equivalent).*	3	We have weekly ward round meetings where patients are discussed. The admission meeting (case presentation) does not take place within one week of admission. It is discussed during ward round session or during the admin meeting. Takes place with all admissions. Done as standard practice.
3.2.8	On admission to the ward/unit, or when the young person is well enough, staff members show the young person around.	2	This is routinely done and often a preadmission visit is also facilitated. This is done prior to admission. i am not sure that it is done on admission. The family with the child is taken round to see the whole unit even on that first assessment interview so that by the time the child is admitted he/she already knows what to expect. This is also to help the family decide whether they would want their child to be admitted there or not. Forms part of the admission process. Done as standard practice.
3.3.1	The unit meets the needs of young people from different ethnic, cultural and religious backgrounds.	2	We get a range of patients from different background and I think we do our best to accommodate - occasionally this is not always possible - e.g. not sufficient staffs available who speaks a child's home language. The unit admits children from all ethnic and cultural backgrounds. I do not think that all staff have adequate cultural competency. This is a specific area that needs addressing. Discrimination at any level is not allowed and this is part of the ward policy and is incorporated as part of the "Never ever" TLC rules. There are a lot of sensitivity re cultural needs, but due to complexity all cannot be individualize – this is at most are being discussed with the family. As much as possible i.e., when risk assessment permits, the ward tries to adapt the conventional ways of working to meet the needs of culturally diverse groups of people. Staff is aware of different cultural norms of the population the ward serves and this is taken to account during assessments and treatment planning.

Chorological Order of Unit Standards for Access, Admission and Discharge (Category 3) Continued

	Unit Standards	Mode	Qualitative Reasoning
3.3.2	The service actively supports families to overcome barriers to access.	1	Ward programme. This is a difficult balance of being flexible and keeping the routine and structure of the ward programme. I think we try to be as reasonably accommodating as possible with families. There is no active support for families who have barriers to access. Indigent families are always assisted with some level of financial support; however, I am not really sure about all the logistics. TLC has established flexible arrangements in order to meet the needs of children, young people and their families who are reluctant to seek help. For example, appointments with various MDT members are scheduled either before or after visiting times, assistance with accessing social support services, assistance with transport money etc.
3.3.3	The ward/unit has access to interpreters and the young person's relatives are not used in this role unless there are exceptional circumstances.	3	There is access to interpreters but these are rarely used. We are lucky that staff members are able to speak more than one language and therefore are able to be utilised in different circumstances whereby there is some language barriers. Interpreters are available via RCWMCH but staff or patient's relatives are often used to assist in history taking due to time constraints both for the parents and clinicians doing the assessments. Clinical and nursing process notes. Staff language proficiency is reflective of the 3 main languages in the Western Cape.
3.4.1	Where young people are not admitted to the service, the reasons are explained to the referrer, and young people and parents/carers where appropriate.	3	For the most part this is done. We do not always make contact with the child themselves but mostly do give feedback to family and referrer. From my own experience, this should be done in writing. As a referrer i often have to follow up what has happened to my referral. I am never informed in a formal way. The referral process takes a long time and there is limited or no feedback to the referrer during this process. This is problematic as the referrer is still seeing the patient and family as outpatients. After the assessment interview, the team already has a sense of whether the child is suitable or not and therefore will discuss the alternative management plan arrange for a follow-up session and communicate this to the family. This forms part of the TLC assessment process as reasons need to be explained to the caregivers and referrer re reasons why the patients are not admitted. Available through clinical file. Feedback is given to referrer and parent/carer.

Chorological Order of Unit Standards for Access, Admission and Discharge (Category 3) Continued

	Unit Standards	Mode	Qualitative Reasoning
3.5.1	During assessment staff involves parents/carers where appropriate.	1	Through ward round notes. We would almost always include parents/caregivers in the assessment process. Parents/carers are always involved in the assessment process. The parent or the primary caregiver is always the one who gives the background history of the child including the history of the presenting problem. The child is also given an opportunity to share about what's been happening in their lives and what do they think is the root of their difficulties. Parents, caregivers or legal guardians always form part of the assessment. Preadmission assessment includes parent/carer clinical interviews; following admission detailed history taking and information gathering involves parents/carers. Specific assessments conducted by different MDT members - depending on the nature of the assessment may include parental participation or feedback.
3.5.2	Carers are advised on how to access a statutory carers' assessment, provided by an appropriate agency/All families have access to an assessment of their needs where appropriate.	1	I imagine this is a UK based question which wouldn't be relevant in our setting. There are no such resources. Parents are informed about stator corers when the need arise, but it's not standard procedure. Following an assessment of need by the TLC team, if indicated referrals are sent to appropriate social/statutory services.
3.5.3	The young person's carer is contacted by a staff member (with young person's consent) to notify them of the admission and to give them the ward/unit contact details.	3	This is done my nursing or case manager. Not applicable as the ward caters for under 13s and no child will be admitted without parents'/carers' consent. Parents or primary caregivers are always the one contacted as this is a children's unit-ages 6 to 12yrs old. The carers are informed about the admission, who responsible for informing the patients. Patients are often on admission not told by the parents in advance about the admission and would only tell the patient when they arrive. Done as standard practice.

Chorological Order of Unit Standards for Access, Admission and Discharge (Category 3) Continued

	Unit Standards	Mode	Qualitative Reasoning
3.6.1	The inpatient team invites a community team representative to attend and contribute to relevant meetings e.g. CPA, discharge planning.	3	I'm assuming by community team representative they mean outpatients or referrer - in which case we would do this as a matter of routine. This happens sometimes. The "community" member is often a member of the OPU psychiatry team. Teachers and social workers do not always attend review meetings. People who are directly involved with the child (Teachers: SW; Referral sources) from different institutions are invited during our case presentations to give their input. Outside social workers and department of education are invited to case presentation to assist in planning for discharge e.g. appropriate school. Done as standard practice.
3.6.2	Discharge planning is initiated at the first multidisciplinary team review and an estimated length of stay is established.	2	Due to the length of admission it is not always possible to give an exact discharge date at the first case presentation - where possible we would try. Discharge planning is not initiated at the first meeting. It should be. Management plan is discussed even before admission and a possible discharge date is always set for the end of term depending on the child's progress. Case presentation is held in a month after the admission date. This is not always possible as a clear sense of patient psychological, medical and academic needs still need to be observed.
3.6.3	When a young person transfers to adult services, unit staff invite adult services and other involved agencies to a joint review to ensure an effective handover takes place and there is a protocol for collaborative working.	1	Not relevant to the TLC which is only children. Not applicable. The ward only caters for up to 13 years so no transfer to adult services is indicated. Children are always given a follow-up plan on discharge and this is done during the parent discharge meeting. Staff of other hospital sometimes attends, but due to workload are not always able to attend. The age group of children admitted to the ward is preteen child; as such they do not require referral to adult services. However, they are linked with appropriate outpatient services according to the current distribution of outpatients' child and adolescent mental health services across from geographic catchment areas. Discharge planning involves holding meetings, invitation to the TLC discharge meeting and discharge summaries to facilitate smooth transfer of care & transition from inpatient to outpatient services.

Chorological Order of Unit Standards for Access, Admission and Discharge (Category 3) Continued

	Unit Standards	Mode	Qualitative Reasoning
3.6.4	A letter setting out a clear discharge plan, which the young person takes home with them, is sent to all relevant parties before or on the day of discharge.	2	Discharge reports. Although this is something we try to do in practice it's not often that a full report is completed and then sent to the referrer. Clear discharge summaries are not give to patients and often not sent timelessly to referrers. There is often not a clear discharge plan. The patient has a comprehensive discharge plan but it is not readily available on the day of discharge.
3.6.5	A written comprehensive summary is produced and distributed within ten days of discharge.	2	Similar to the previous response we do try but in practice often don't complete a summary within 10 days. Discharge summary is not distributed within ten days. It is given during the parent discharge meeting. The written summery isn't ready within 10 days as the MDT members takes some time before submitting the report due to other commitments and workloads. Done as standard practice - A comprehensive TLC report is always completed and distributed however, collation of information and completion of the comprehensive MDT report (usually 15 - 20 pages) takes is a lengthy process, and thus it may be completed within or sometimes after 10 days.
3.6.6	The young person and their carer (with young person's consent) are invited to a discharge meeting and are involved in decisions about discharge plans.	2	We routinely have discharge meetings for families though rarely do these include the child. Only the caregivers/ parents or legal guardians attend the discharge meetings, but not the patients. Discharge plane are being discussed with patients with their individual therapists. Parents/carers are invited to a discharge meeting. Information given to children is determined by their developmental level.
3.6.7	There is a procedure in place for taking action on delayed discharge.	2	Generally any delay in discharge is discussed amongst the team and (the only reason I've put partially is I'm not aware that this is process is formalised in a document). Cases are being discussed individually depending on the circumstances. The unit has a standard operating procedures for escalating social and educational placement delays which delay discharge.

Chorological Order of Unit Standards for Access, Admission and Discharge (Category 3) Continued

	Unit Standards	Mode	Qualitative Reasoning
3.6.8	The team provides information, signposting and encouragement to young people to access local organisations such as: • Voluntary organisations; • Community centres; • Local religious/cultural groups; • Peer support networks; • Recovery colleges.	2	There are fairly limited such organisations available but where possible we would try to do this. From my own experience. When indicated the team makes appropriate referrals to community organisations. There are very few community organisations that offer services for these children. Parents are advised as such during the discharge meeting. The team does provide parents/carer and children information, signposting and encouragement to access local organisations.
3.6.9	The team makes sure that young people who are discharged from hospital to the care of the community team have arrangements in place to be followed up within one week of discharge, or within 48 hours of discharge if they are at risk. Young people should be aware of the follow up arrangements.	2	It is not always possible for this kind of arrangement to happen - certainly we would look to make sure they have an apt with OPU/referrers soon after discharge (though not always within a week). From my own experience. The children are not usually seen for follow up within a week of discharge. Follow up appointments are not always given on discharge and should be. The patients are not always followed up within one week of discharge due to workload within the community. Follow up appointments are given before or on discharge and beyond 1 week. If they are at risk, they are discharged with a secured follow up appointment.
3.6.9	Young people are supported by staff members, where required, to access care from other physical health services to meet their needs. This includes: - Accident and emergency; - Social services; - Local and specialist mental services (e.g., liaison, eating disorders and rehabilitation) - Secondary physical healthcare	3	This would certainly happen in conjunction with the main hospital or other community services. All children are referred externally for input and support but it does not always happen. Dates for specific appointment are set, transport to RCWMCH remains a challenge as patients wait lengthy times for the ambulance to collect the patients. Children are assisted to access care from other physical health services to meet their needs including other medical specialties or sub-specialties; allied health services and social services. When clinically indicated, facilitation of referrals for parents/carers and/ or siblings to access mental and other health care services or social services are made.

Chorological Order of Unit Standards for Access, Admission and Discharge (Category 3) Continued

	Unit Standards	Mode	Qualitative Reasoning
3.6.10	When young people are transferred between wards/units there is a handover which ensures that the new team has an up to date care plan and risk assessment.	3	Patient notes. This would routinely happen. Not applicable. There is no other ward to transfer them to. Transfer of care to another unit is rare as the TLC is the only inpatient child psychiatry service and patients are carefully assessed prior to admission. On the rare occasion when this happens, up to date care plans and risk assessment and risk management plans are handed over to the receiving team.
3.6.11	The team follows a joint working protocol/care pathway with the Home Treatment/Crisis Resolution team in wards/units that have access to one. *Guidance: This includes the team inviting the Home Treatment Team to attend ward rounds, to screen for early discharge, to undertake joint acute care reviews and to jointly arrange supported leave.*	1	We don't have such teams that I'm aware of (clearly they are part of standard practice in the UK). Not applicable. We don't really have any home-based carers. Carers from children's homes are also involved in the treatment and management plan including doing a home visit with our social worker. This standard is not fully applicable to our context as current child mental health services do not comprise of Home Treatment/Crisis Resolution teams. However, outpatient clinicians, when appropriate are invited to attend ward rounds, case presentations and discharge meetings as part of joint/collaborative work.

Appendix F

Chronological Order of Unit Standards for Care and Treatment (Category 4)

	Unit Standards	Mode	Qualitative Reasoning
4.1.1	Young people have a risk assessment which is completed using a formal tool and includes a comprehensive assessment of: risk to self; risk to others; risk from others.	3	In patient files. These are completed by senior/registrars. This takes place on admission. It should also take place during the admission and on discharge. Risk assessment forms part of the medical assessment on admission. Clinical notes - Risk assessment form. Done as standard practice.
4.1.2	Risk assessments and management plans are updated according to clinical need and as part of care planning meetings at a minimum.	3	In patient folders. This is discussed at ward rounds where relevant. Management plans are reviewed at weekly ward rounds. Risk assessments need ongoing review. One of the important parts of the first medical assessment to determine type of nursing care e.g. 1:1 or 1:2. Clinical notes - Risk assessment form. Done as standard practice.
4.1.3	Young people have a comprehensive physical health review. This is started within 4 hours of admission and is completed within 1 week, or prior to discharge.	3	This would be better answered by the doctors (I don't believe ECG's are done routinely but certainly physicals are). This should be met. Clinical notes - physical examination form and nursing process notes. Done as standard practice.
4.1.4	If part or all of the examination is refused, the reason why has been recorded and repeated attempts has been made to complete this process.	3	These would be recorded in patient notes. I am unsure if the examination does not take place whether this standard is met. Parents make the decision. When this happens, reasons are clearly documented.

Chronological Order of Unit Standards for Care and Treatment (Category 4) Continued

	Unit Standards	Mode	Qualitative Comments
4.1.5	Young people have follow-up investigations and treatment when concerns about their physical health are identified during their admission. *Guidance: This is undertaken promptly and a named individual is responsible for follow-up. Advice may be sought from primary or secondary physical healthcare services.*	3	Any concerns would be followed up with the relevant specialists (any delays would usually be because of waiting lists). It is not always clear whether this is followed up and by whom. Clinical notes, referral letters and special investigation results. Done as standard practice.
4.2.1	Young people are offered pharmacological and psychological interventions in accordance with the evidence base and good practice.	3	As much as possible we try to use evidence base treatment but it is not always possible to access such services (e.g. EMDR). It is not always possible to offer evidence based interventions as we do not always have the skill set required. Clinical notes. Done as standard notes.
4.2.2	Inpatient services have a range of interventions available. These include: Medication; Individual therapy (e.g. psychotherapy, CBT etc.) provided by a qualified therapist; Therapeutic Group Work; Family Therapy; Occupational Therapy; Parents/carers feel supported by the ward staff members. *Guidance: This could be through the provision of or sign-posting to carer support networks or groups. There may be a designated staff member dedicated to carer support;* Art/Creative Therapies	3	According to the ward programme, suppose it depends what we're comparing this to but broadly I would say there's a broad range of services that the children routinely access. The inpatient ward does not have sufficient OT time to meet the OT needs of the children. There is no family therapist. All the therapeutic needs are not always met due to lack of staff with the necessary skill set to meet the needs of the patients. We work as a team (MDT) and we are affiliated to a children's hospital (RXWMCH). Medication is supplied by the hospital's pharmacy. Clinical notes. Done as standard notes.

Chronological Order of Unit Standards for Care and Treatment (Category 4) Continued

	Unit Standards	Mode	Qualitative Comments
4.3.1	Every young person has a personalised structured timetable of meaningful activities.	3	For the most part we have a standard programme that the children follow, it does get adapted individually as needed. There is meant to be a structured timetable during the day but this is not always personalised. The programme is fully visible on the wall and the kids are orientated to it. All patient attends the structured ward programme, their individual therapy times and other commitment isn't always at the same time per week, due to staff work load. TLC patient therapeutic programme - weekly, weekend and holiday programmes, nursing process notes. Done as standard practice.
4.3.2	There are a range of accessible activities are provided everyday including evenings, weekends and bank holidays. *Guidance: Activities which are provided during working hours, Monday- Friday, are timetabled.*	3	There is a holiday and weekend programme for staff and children to follow. Activities during the week are scheduled but weekend activities are not always scheduled. There is a daily programme and a holiday programme planned. Weekends are unstructured a holiday programme have been introduced which are being conducted by the nursing staff. TLC patient therapeutic programme - weekly, weekend and holiday programmes, nursing process notes. Done as standard practice.
4.3.2	Young people and the team can obtain a second opinion if there is doubt, uncertainty or disagreement about the diagnosis, formulation or treatment.	2	We are able to access second opinions from other DCAP colleagues and those in other relevant hospitals (e.g. Tygerberg, Lentegeur). It is not always possible to obtain a second opinion. Usually we are able. The team has a good relationship with the clinicians from other hospitals including private institutions, therefore there is constant consultation whenever the need arises. The team normally ask for a second opinion but the patients seldom ask, I don't they are aware of the option to request a second opinion. Second opinions may be requested from our DCAP outpatients unit colleagues and/or cross platform colleagues i.e., from other child and adolescent psychiatry services - Lentegeur hospital or Tygerberg hospital.

Chronological Order of Unit Standards for Care and Treatment (Category 4) Continued

	Unit Standards	Mode	Qualitative Comments
4.3.2	Where appropriate, young people are actively involved in shared decision-making about their mental and physical health care, treatment, discharge planning and are supported in self-management.	3	Patient notes. We try to involve the children as much as possible and as clinically indicated, in their care Children's views are not actively sought. As far as possible yes. Children are not always able to make informed decisions as their brains are not fully developed to independently engage in such. However, their thoughts and feelings are always taken into considerations when decisions are made. Patients are often asked about their needs where appropriate. Clinical notes and nursing process notes. Done as standard practice.
4.3.2	Young people and parents/carers are supported by staff members, before (to prepare), during (to understand and contribute) and after (to feedback outcomes) any formal review of their care.	3	I'm not entirely clear what a 'formal review of their care' constitutes? But certainly for case presentations we would try to include children and families before and after the process. The young person is not actively involved in their care management plans. Carers are more involved but need to be more supported to be co-participants in the care of their children. Doctor always informs the children at the level that they can understand and also liaises with parents/ cares about the developments at large. Done as standard practice by case manager, contact nurse and/or appropriate MDT members e.g., Psychiatrist, Clinical Psychologist and Social Worker.
4.3.3	The team gives targeted lifestyle advice and provides health promotion activities for young people. This may include: physical exercise advice; healthy eating advice; smoking cessation advice.	3	Some of those may be less relevant for children (e.g. smoking only occasionally comes up) but mostly we would do this as required. There is not enough healthy lifestyle advice. Children are given health education talks by the in-house teacher. Clinical notes, nursing process notes, dietician notes. Done as standard practice.
4.3.4	Young people's preferences are taken into account during the selection of medication, therapies and activities and acted upon as far as possible.	3	As much as possible we would try to account for and incorporate children's preferences in to the programme, obviously balanced with our resources and limitations as a ward. Very little if any involvement of the children in their ongoing care planning.

Chronological Order of Unit Standards for Care and Treatment (Category 4) Continued

	Unit Standards	Mode	Qualitative Comments
4.3.5	Young people and parents/carers have access to key members of the MDT outside of planned meetings to review their progress.	2	There is a case manager who routinely checks in with families and nursing staff who do something similar as needed. Children are also reviewed and consulted on a regular basis. There are regular meetings with carers to discuss care planning but I am not sure how actively involved the children are in these processes. Usually they have. We have a resident senior registrar who sees the children on a daily basis. Clinical notes. Done as standard practice.
4.4.1	All young people have a documented diagnosis and/or clinical formulation which is discussed with them. *Guidance: The formulation includes the presenting problem and predisposing, precipitating, perpetuating and protective factors as appropriate.*	3	We do put together formulations for case presentations though these are not always routinely done. To an age appropriate level these and the diagnosis are discussed with the child. This does not happen. This is discussed with the parents after every case presentation. Clinical notes, TLC case presentation reports and discussion. Done as standard practice.
4.5.1	Care of all young people takes place within a formal Care Programme Approach framework or local equivalent	3	I'm not familiar with a Care Programme Approach framework. There are detailed discharge summaries with recommendations for ongoing care. Treatment is always formulated to suit each child's needs. Clinical notes, patient management plans. Done as standard practice.
4.5.2	Young people are facilitated and supported to prepare for any formal review of their care. *Guidance: an advocate may help young people to do this.*	2	Again I'm not sure that we have formal reviews in the way they are suggesting. We do include children as best we can in case presentations. There are no advocates for the children. Usually not a feature in our patients but can be done. Due to their age this is discussed with parents. Done as standard practice. This is done according to the children's developmental level.

Chronological Order of Unit Standards for Care and Treatment (Category 4) Continued

	Unit Standards	Mode	Qualitative Comments
4.5.3	Young people and parents/carers are supported to contribute and express their views during reviews.	2	Assuming this is case presentation we routinely inform children and incorporate their views. Parents/carers views are sort. Not sure how actively the children's views are sort. They are reviewed daily by resident senior registrar and all their concerns are addressed. Done as standard practice. Parents/carers are supported during parent feedback meetings, children are also given feedback according to their developmental stage and supported through the process.
4.5.4	Young people and parents/carers know who is coordinating their care on the unit and how to access them if they have any questions.	3	According to Case management and special nurse system. For the most part children are aware of their special nurse (when that system ran) and their case manager. They are aware of how to meet them. The children are not always aware who their care co-coordinator is. Parents have access to the unit's phone numbers. Clinical notes and nursing notes. The allocated case manager informs the parent and allocated contact nurse informs the child.
4.5.4	The team reviews and updates care plans according to clinical need or at a minimum frequency of a month. *Guidance: The care plan clearly outlines: Agreed intervention strategies for physical and mental health; Measurable goals and outcomes; Any advance directives or statements that the patient has made; Crisis and contingency plans; Review dates and discharge framework.*	2	At ward rounds, but maybe not to the level being described here. The case presentations don't happen as often as monthly. This is done weekly during ward rounds. Clinical notes, nursing process notes; and case presentation reports and discussion notes. Done as standard practice.
4.5.5	Parents and carers are offered individual time with staff members, within 48 hours of the patient's admission to discuss concerns, family history and their own needs.	2	On admission carers and children would meet some staff as part of their admission process. They wouldn't however be routinely offered individual meetings with specific staff members unless asked for. This does not always take place within 48 hours of admission. Parents see a family therapist or a resident psychologist weekly to discuss concerns and their children's progress. Parents/ carers are able to discuss concerns, family history and their own needs during admission by nursing staff and the admitting doctor. Further, parents/carers are able to further discuss these during dedicated history taking sessions conducted by Psychiatry and Social worker.

Chronological Order of Unit Standards for Care and Treatment (Category 4) Continued

	Unit Standards	Mode	Qualitative Comments
4.5.6	The practitioner develops and reviews the care plan collaboratively with the young person and their carer (with young person consent).	2	In patient notes. We would try and include families and children in care planning. I'm not sure we have a formal care plan set out as they're suggesting. The young person is not often involved with the care plan. The carers are involved to a greater extent. Clinical notes and nursing process notes. Done as standard practice.
4.5.7	All young people sign their care plan.	1	We don't have a formal care plan written out that patients sign. This is not done on the unit. The care plan is not always even explained to the child in a manner which s/he understands. Our patients don’t sign a care plan. Care plans are formally signed by the allocated case manager and nursing care plans are signed by nursing staff.
4.5.8	The young person and their carer (with young person consent) are offered a copy of the care plan and the opportunity to review this.	1	As stated before. Usually initially verbal feedback and discussion. Care plan given after first case review meeting. Not applicable due to the child’s age. Parents/carers are given copies of completed parent feedback forms which clearly outline care plans which they may share with their children; however children are not formally given a copy.
4.5.9	Each young person has a pre-arranged session with their key worker at least once a week to discuss progress, care plans and concerns.	1	We have a case management system but they do not meet with the children on a weekly basis as part of that role. The child does meet with the senior registrar/M.O. on a weekly basis. This does not happen. Formally 'special-time' session notes by allocated nurse therapist. Currently, some aspects of this standard are covered in weekly. Psychiatry review notes which are in the clinical notes.
4.5.10	If a local authority has parental responsibility as a result of a care order, the hospital should obtain the named social worker’s consent where necessary and consult on the young person’s care plan.	3	We do include DSD or relevant children's home social worker as required but again don't have care plans in the way they are being described. There are active attempts to engage the external social worker. Clinical notes - Social Work section, copies of care orders. Done as standard practice.

Chronological Order of Unit Standards for Care and Treatment (Category 4) Continued

	Unit Standards	Mode	Qualitative Comments
4.5.11	When a care order is in place the Local Authority is asked to confirm who should be consulted about treatment decisions and other aspects of the child's care plan.	3	Relevant social workers are routinely asked about this if needed. Not applicable. Clinical notes - Social Work section. Done as standard practice.
4.6.1	The unit provides the core educational subjects: Maths, English and Science.	2	Based on my observations and understanding they do the core subjects including English, Afrikaans, Maths and Life Orientation. I'm not aware of science (although that might include some science). Discussion with the teacher and classroom assistant. WCED curricula followed. We do discuss social science during teaching time but we do not formally assess it. We formally assess the languages, English and Afrikaans, Mathematics and Life Skills. Only Math, English, Social Science, Life Skills and Afrikaans are covered. The question is incorrect as the subjects concentrated on are the languages, math and life orientation.
4.6.2	The unit provides a broad and balanced curriculum that is suitable and flexible, appropriate to the students' needs.	3	I understand that the curriculum is flexible and adapted according to the needs of the children. School in ward caters for individual needs. Our patients are offered Occupational Therapy, Art Therapy, Yoga as well as swimming. These activities form part of the academic programme.
4.6.3	Where the unit caters for young people over the age of 16, young people are able to continue with education.	1	Not applicable. Not applicable, only caters for under 13s. Older learners can be seen in the Out Patient Unit. Patients over the age of 13 can be seen as inpatients at the Tygerberg or Lentegeur Unit. As mentioned, the ward and schooling component only caters for under 13s. The TLC does not admit over the age of 13.

Chronological Order of Unit Standards for Care and Treatment (Category 4) Continued

	Unit Standards	Mode	Qualitative Comments
4.6.4	Teaching staff complete an assessment of each young person's educational needs which is reviewed at each CPA review (or local equivalent).	3	To my understanding assessments are done on a regular basis. Teaching needs discussed at review meetings. Some children are not able to work on their grade level when they are admitted. It takes a while for them to settle. We sometimes have difficulty getting reports and feedback from schools. I do get support from my curriculum adviser. But it takes a while for the patients to be assessed by a Psychologist. It is important that the children continue to be educated and treated as normal as possible.
4.6.5	All young people have a personal education plan which reflects the focus on wider progress and wellbeing in education in addition to academic progress. *Guidance: Mental Health Functioning in Education can be used to show focus on wider progress.*	3	Usually focuses on educational needs. Each learner's goals are integrated in the daily programme. The learners are encouraged to keep their goals in mind and they are rewarded with stars when they achieve it. This is dependent on the level of the patient's academic integrity and grade level. The patients are seen by the MDT who keep records documenting interventions as well as progress.
4.6.6	If the young person is receiving education, educational staff at the unit must liaise with the young person's own school in order to maintain continuity of education provision.	3	We certainly aim for building good relationships with the child's school though for multiple reasons this is not always possible. Also look to include Dept. of Education as much as possible. Liaison between teacher and local school teacher regularly takes place. It is not easy to maintain a relationship with some school. As they do not immediately respond to our request to send reports, work assignments and assessments for the learner. Sometimes it difficult to contact independent and home schools as they take a while to connect. I usually contact my curriculum adviser when i have difficulty with government schools. She will then contact them and I will usually get a positive reaction. Liaison with patient's school is consistent and needed. It is the aim to connect with the mainstream school. Sometimes they are not very cooperative and this definitely hampers relationships.

Chronological Order of Unit Standards for Care and Treatment (Category 4) Continued

	Unit Standards	Mode	Qualitative Comments
4.6.7	Where young people are returning to their local educational facility after discharge, education and unit staff support the young people with their reintegration.	3	From patient notes and personal experience. We try to support patients with an individualized bridging plan, in collaboration with their school, caregivers and the child themselves. Reintegration into schools used to take place. Nursing staff were integrally involved. Now that nursing staff are less experienced and also not allowed to work off site, this re integration has decreased considerably. The team agrees to a bridging plan involving dates and times. The school is informed about the bridging. They are asked to agree to dates and times that will cause the minimum disruption for the school and the learner. The parents are informed as they have to accompany the learner and fetch them from school. Circumstances and transport of the parent is also considered when the plan is finalised. Reintegration plays a major part of the bridging and discharge phases of the patient's admission. The children are bridged very carefully over a period of time to their new school. This is done in consultation with the MDT.
4.6.8	The educational staff maintain communication with the young peoples' parents/carers, e.g. providing progress reports for each CPA review.	3	There is, to my understanding, good communication where appropriate with caregivers. I am not sure that written progress reports are given Each child has a case presentation at least once a term. All important stake holders are invited and has to present their evidence and findings concerning the learner. A feedback meeting is arranged with the parents where this information is shared with the parents or caregivers. Communication from the schooling staff and respective parents/carers is maintained. The consistency of this communication can be difficult due to the lack of responsiveness and reliability from some parents/carers. The parents form a vital role and they have to give a solid commitment before the child is admitted to the TLC.

Chronological Order of Unit Standards for Care and Treatment (Category 4) Continued

Unit Standards		Mode	Qualitative Comments
4.6.9	Educational outings are provided, as appropriate.	2	Over the last number of years and where possible this has been done, though more recently it has become difficult given restrictions from hospital management. Regular educational outings took place but recent hospital regulations have meant that there are fewer educational outings. The last two years has been challenging to arrange excursions. After going through all the planning stages and getting permission all excursions were abruptly stopped. A new policy had to be drawn up by management which took a few months to be sorted out. After almost a year we were told that we could now arrange excursions Recently established hospital regulations from the main hospital have limited the approval of excursions for the patients. The school is willing to take the children on outings but we have to be guided by the hospital management.
4.6.10	Teachers contribute to multi-disciplinary meetings.	2	Available through ward round notes. The teacher attends a range of regular staff meetings. Teachers are usually present at MDT meetings. There were times when the learners and parents were informed about plans regarding the learner's schooling without informing the teaching staff. School visits were arranged without inviting the teacher or invitations on short notice. Sky-ping with a learners school was also done during school holiday when the teacher was not available. They play an integral part to admin; ward round, case presentations and goals and strategies meetings. The teacher's input is highly valuable in the discussion of the children.

Chronological Order of Unit Standards for Care and Treatment (Category 4) Continued

	Unit Standards	Mode	Qualitative Comments
4.6.11	Teachers and nursing staff have a handover at the beginning and end of each school day.	2	I'm aware that there is a regular staff hand over I don't know about a regular meeting with teaching and nursing. There is no formal handover at the beginning and end of each day. On some days one of the nurses will come and share information with me regarding the patients. Sometimes I will go to the nurses to inquire about the learners and how they have been the previous day. Although the nurses meet at hand over and the other team members also get together in the morning the teaching team is not included in these sessions. There is also no formal handover after school. I will share important information regarding a patient with the nursing staff I am unsure of this.
4.6.11	When young people are absent without leave, the team (in accordance with local policy): • Activates a risk management plan; • Makes efforts to locate the young people; • Alerts carers, people at risk and the relevant authorities	3	In the cases where this does happen we would contact the relevant stakeholders as required. This has hardly ever happened but when it did the management was as described. Patients usually sign in from the weekend on a Sunday afternoon. They are then seen by the doctor on call. If a patient does not sign in by 16h 00 the parents are contacted. On a Monday morning we will be informed by the staff and all relevant stake holders are informed It is very important especially at a unit like the TLC as it is important to find out the reason and help provide solutions.
4.6.12	The unit must be part of an education organisation that is a registered examination centre.	3	I'm not sure what are equivalent would be of a registered exam center (or how relevant in our context). I presume this would be the Western Cape Education Dept. If that is the case then I imagine this would be fully met. Follows WCED principles. The unit is part of Red Cross Hospital Primary School which is registered with the WCED. The teacher at the unit is a Qualified teacher who is permanently employed by WCED. She attends all the meetings and training provided by WCED. The curriculum adviser visits the unit to provide guidance. The school gets accommodation assessments in order that the evaluation process can continue.

Chronological Order of Unit Standards for Care and Treatment (Category 4) Continued

	Unit Standards	Mode	Qualitative Comments
4.7.1	Clinical outcome measurement data is collected at two time points (admission and discharge as a minimum and at clinical reviews where possible (e.g. HoNOSCA, SDQ etc).	2	SDQ's are used though they are not always collected. Other global assessments are also used. Some clinical outcome measures are obtained at discharge. SDQ questionnaires - preadmission assessment (time point) and discharge. C-GAS Scores - Case presentations (time point) and discharge. These are not consistently administered by staff, completed by parents/carers and/or scored.
4.7.2	Outcome measurement tools are completed from the perspective of staff, young people and/or parents/carers.	2	Parents and carers routinely complete the outcome tools rather than the children. The children's perspectives are usually collected qualitatively and in interviews. The young person's views are not always collected. Usually all parties are involved. SDQ questionnaires:- parent/teacher (P 4-16) and older children (S 11-17). SNAP Rating scale completion by teacher, nurses and parents/carers. SDQ questionnaires: older children (S 11-17) version is less consistently administered that the parent/teacher (P 4-16) version.
4.7.3	Individual outcome measurement data is discussed with the young person as part of their care planning e.g. Goal based outcomes.	1	This is not routinely done. This is not done. Feedback is usually given and discussed. Not consistently done - differs on a case by case basis.
4.7.4	Outcome data is used as part of service management, staff supervision and development.	1	There was a period where this was done more routinely but is not currently done. There is a box for complaints and appraisal comments that is forwarded to HR at frequent intervals for review and feedback is given to appropriate disciplines. Parent/carer completed complaints and compliments forms, SDQ questionnaires. The unit doesn't always get feedback on parent/carer completed complaints and compliments forms.

Chronological Order of Unit Standards for Care and Treatment (Category 4) Continued

	Unit Standards	Mode	Qualitative Comments
4.7.5	Information from outcome measurement is fed back to the whole staff team, users and commissioners.	3	In discharge summaries. When collected the data is put in the discharge summaries which goes to referrers. Feedback on outcome measures is not done. As stated before. SNAP rating scale outcomes are fed to the whole team at ward rounds and case presentations. The importance of administration, completion and scoring of outcome measures is always discussed at bi-annual TLC review meetings.
4.7.6	Units contribute to a national dataset to allow for information sharing e.g. QNIC ROM.	1	There is not a national database that I'm aware of. Too expensive for our service to participate in QINIC. CLINICOM - electronic clinical data management system. Not aware of national quality network dataset to allow for information sharing e.g. QNIC ROM - RCWMCH Information management department will have this information.
4.8.1	Young people are provided with meals which offer choice, address nutritional/balanced diet and specific dietary requirements and which are also sufficient in quantity. Meals are varied and reflect the individual's cultural and religious needs.	3	To my knowledge the hospital meals are designed to provide for all the children nutritional needs. Patients receive hospital food which is not always nutritious. The kids get the same full ward diet from the hospital's main kitchen, unless otherwise stated. The meals are balanced but patient don't have a choice. Special diets are being catered for. Children are provided a choice of food which is prepared safely and provides a balanced diet, and individual clinical, nutritional, cultural/religious dietary requirements are considered. The hospital kitchen diet is not always able to accommodate personal preference.
4.8.2	Staff ask young people for feedback about the food and this is acted upon.	2	Occasionally children are asked but there is little that can be done as the hospital meals are fairly standard. Views on food are not formally requested, Children give feedback and if there are major problems, these are communicated with the dietician. Nursing process notes, TLC ward - kitchen stock/food requisition forms. Requested items are not always available.

Chronological Order of Unit Standards for Care and Treatment (Category 4) Continued

	Unit Standards	Mode	Qualitative Comments
4.8.3	Where there is a therapeutic benefit staff eat with the young people at mealtimes and the cost of the staff meal is covered by the organisation.	2	Occasionally for eating disordered patients this may happen. Not sure about this. If it happens it only applies to nursing. Staff eats with the patients whenever possible but the hospital does not supply meals for staff. Nursing process notes, clinical notes, CCTV footage. This would occur under very specific circumstances, with a clear clinical indication and evidence based therapeutic effect.
4.8.4	Where there is a therapeutic benefit, there are arrangements for families to eat at mealtimes and the cost of the meal is covered by the organisation. *Guidance: Therapeutic benefits may include working with ED young people, social interaction, normalisation, role-modeling etc.*	1	We haven't done this to my knowledge - though I imagine if needed it could be arranged. As described above, for patients with eating disorders as part of family based therapeutic intervention.
4.9.1	The team develops a leave plan jointly with the young person and parent/carer that includes: • A risk assessment and risk management plan that includes an explanation of what to do if problems arise on leave; • Conditions of the leave; • Contact details of the ward/unit.	3	Patient notes. This routinely done. The leave plans are discussed with the carers. the children are usually informed of the leave plan arrangements rather than having it discussed and agreed with them. The family therapist or resident psychologist designs a calendar for the parent indicating the start of leave and the comeback date. This includes the management plan in time of crisis. Clinical notes and nursing process notes. Done as standard practice.
4.9.2	There is a weekly minuted community meeting that is attended by young people and staff members. *Guidance: This is an opportunity for young people to share experiences, to highlight issues on the ward/unit and to review the quality and provision of activities with staff members. The meeting should be facilitated by a professional who has an understanding of group dynamics.*	2	This is not done. This is an excellent idea but does not take place in the ward at present. Community meeting type feedback is gathered. We have a “worry group” that is held at random intervals to address issues that randomly come up. Community meeting/ feedback are done every day and documented in the patient nursing notes. Currently not done routinely. Worry groups facilitated by experienced nursing staff are held intermittently where children can share experiences, highlight issues on the ward/unit to staff members.

Chronological Order of Unit Standards for Care and Treatment (Category 4) Continued

	Unit Standards	Mode	Qualitative Comments
4.9.3	Young people have access to relevant faith-specific and/or spiritual support, preferably through someone with an understanding of mental health issues.	1	This is not something we do. I recall on one occasion a faith based person coming to the ward at the request of the patient's family. This is not offered on the ward although the hospital has various faith based voluntary people who offer support. I don't think we do this often. That issue is dealt with by the children's parents. This are accommodated on patients/family request and relevance discussed in ward round. When specifically arranged by parents/carers relevant faith-specific and/or spiritual support is provided to children, usually when children are at home during weekend or holiday home-leave periods.
4.9.4	Young people have their medications reviewed at least weekly. Medication reviews include an assessment of therapeutic response, safety, side effects and adherence to medication regime. *Guidance: Side effect monitoring tools can be used to support reviews.*	3	This would be best answered by the doctors. The children have a weekly review on the ward by the ward doctor. Progress is reviewed daily during our 8am feedback meeting and also during our weekly ward round. Clinical notes, specific medication adverse effects monitoring tools e.g., stimulant medication side effects rating scale. Done as standard practice.
4.9.5	When young people experience side effects from their medication, this is engaged with and there is a clear care plan in place for managing this.	3	This would be best answered by the doctors. As stated before. Discussed with the registrar on call, symptoms monitored, discussed with the MDT, managed accordingly dependent on symptoms. Clinical notes and ward round forms. Done as standard practice.
4.9.6	The team follows a policy when prescribing and dispensing PRN (i.e. as required) medication.	3	This would be best answered by the doctors. There is no policy for PRN medication. There should be a policy. Reviews are done daily to check progress and PRN meds are given accordingly. Inpatient medication prescription sheets. Done as standard practice.

Chronological Order of Unit Standards for Care and Treatment (Category 4) Continued

	Unit Standards	Mode	Qualitative Comments
4.9.7	Young people have access to a specialised pharmacist and/or pharmacy technician to discuss medications.	2	Any medication related matters would be discussed with the medical officer (who sees the children weekly). To that extent I'm not sure if that replaces the need for access to a pharmacist? This service is not offered by the pharmacy dept. Dr. is the one who discusses medication with the pharmacist. Not applicable. Children can raise concerns with registrar on call or individual therapist. Young children admitted in the ward usually do not discuss medication directly with pharmacy staff, however parents/carer, nursing staff and doctors looking after them have access to a pharmacist or pharmacy assistant.
4.9.8	The safe use of high risk medication is audited, at least annually and at a service level. *Guidance: This includes medications such as lithium, high dose antipsychotic drugs, antipsychotics in combination*	2	There is currently no auditing of medication usage. At service/ward level such audits are not consistently conducted.
4.9.9	Young people with poor personal hygiene have a care plan that reflects their personal care needs. *Guidance: This could include encouragement to have regular showers and to shave, referral to a dentist for oral dentition, referral to a podiatrist for foot care.*	3	This is something that would get discussed on a regular basis at ward rounds and with nursing and appropriate planning put in place. This would happen as part of goals and strategies for each child if indicated. We have supervised washes each day and children are encouraged and praised for taking care of them. If there are problems with dental or feet care parents usually book them to their specialist doctors or our doctor also takes that initiative. Nursing care plans and nursing process notes. Clinical notes and referral letters to dentists etc. Done as standard practice.
4.9.10	The ward/unit has a policy for the care of young people with dual diagnosis that includes: • Liaison and shared protocols between mental health and substance misuse services to enable joint working; • Drug/alcohol screening to support decisions about care/ treatment • Liaison between mental health, statutory and voluntary agencies; • Staff training; • Access to evidence based treatments; • Considering the impact on other young people of adverse behaviours due to alcohol/drug abuse.	2	It's rare that dual diagnosis comes up in the ward so we don't have an official policy that I'm aware of. However, we would follow through with the necessary support and referrals etc. as needed. No dual diagnosis programme. But we don’t often have dual diagnosis patients. No available evidence. Dual diagnoses as narrowly defined in this standard refer to dual diagnoses of a mental disorder + substance use disorder. Due to the young age of children admitted in the ward, dual diagnoses treatment is not offered in the unit.

Chronological Order of Unit Standards for Care and Treatment (Category 4) Continued

	Unit Standards	Mode	Qualitative Comments
4.9.11	Long-stay young people who are prescribed mood stabilisers or antipsychotics are reviewed at the start of treatment (baseline), at 3 months and then annually unless a physical health abnormality arises. The clinician monitors the following information about the young person: • A personal/family history (at baseline and annual review); • Lifestyle review (at every review); • Weight (every week for the first 6 weeks); • Waist circumference (at baseline and annual review); • Blood pressure (at every review); • Fasting plasma glucose/ HbA1c (glycated haemoglobin) (at every review); • Lipid profile (at every review).	3	These kind of things would be routinely checked to my knowledge, but this is best answers by the doctors. Not all of the review criteria are met. Clinical notes and special investigation results. Done as standard practice.
4.9.12	Young people are told about the level of observation that they are under, how it is instigated, the review process and how their own perspectives are taken into account.	3	I would say that, to the level of the child's developmental level this is done. Children have very little opportunity to express their views. These are young children who are cognitively not at a high level of functioning but are however engaged daily in their treatment process at a level that they can fully understand and digest. Nursing process notes and clinical notes. Done as standard practice.
4.9.13	Young people are treated with compassion, dignity and respect. *Guidance: This includes respect for a young person's race, age, sex, gender reassignment, marital status, sexual orientation, maternity, disability and social background.*	3	Based on personal observation, I would say this is done. We sincerely believe that this is the case. If this does not happen, the concerns will be dealt with. The children's behavior is guided by the set of rules which they are supposed to abide by to help shape their behavior for their own benefit. Part of the group rules is to "Be polite to each-other." There are also the "Never ever rules. And the" TLC big rules" which involve safety issues. Staff members are also expected to show love and respect at all times. Bato Pele Principles, Patient Rights Charter, Charter of nursing practice, HPCSA regulations, MHCA and Children's Act regulations, nursing process notes and clinical notes. Done as standard practice.

Appendix G

Chronological Order of Unit Standards for Information, Consent and Confidentiality (Category 5)

	Unit Standards	Mode	Qualitative Reasoning
5.1.1	Clear information is made available, in paper and/or electronic format, to young people, carers and healthcare practitioners on: • A simple description of the ward/unit and its purpose; • Admission criteria; • Clinical pathways describing access and discharge; • Main interventions and treatments available; • Contact details for the ward/unit and hospital	3	This is routinely done (preadmission visits are also included where possible). Some of this information is given prior to and on admission. Not all of it is available. The information package is given during the first assessment interview. Made available via the TLC Information pack, TLC Ward therapeutic programme. Done as standard practice.
5.1.2	The service has a website which provides information about the unit that young people and parents/carers can access prior to admission.	1	There is are Red Cross and UCT websites but there is very limited information on the TLC within them. There is no website for the unit. There is a brief website explaining the whole service but it is limited. No website. Made available via Division Child and Adolescent Psychiatry (DCAP) electronic brochure – the unit does not have a dedicated website.
5.2.1	Information, which is accessible and easy to understand, is provided to young people and carers.	3	The information pack has a specifically designed section for children. Information is provided. Not sure how easy and accessible it is for the young person. Booklets are handed over for ASD; ADHD; & ADD. Information for parents/carers and information for children sections is done as standard practice. Currently, the unit is working on drafting additional admission/welcome packs' for children and parents/carers.

Chronological Order of Unit Standards for Information, Consent and Confidentiality (Category 5) Continued

	Unit Standards	Mode	Qualitative Reasoning
5.2.2	The young person is given an age appropriate 'welcome pack' or introductory information that contains the following: • A clear description of the aims of the ward/unit; • The current programme and modes of treatment; • The ward/unit team membership; • Personal safety on the ward/unit; • The code of conduct on the ward/unit; • Ward/unit facilities and the layout of the ward/unit; • What practical items can and cannot be brought in; • Resources to meet spiritual, cultural and gender needs	2	I think some of this information is given in the preadmission pack, though there is not a specifically designed 'welcome pack' for children. The information pack does not take into account all the information suggested. Has some but not all the information listed in this standard is in the TLC information pack. Currently, the unit is working on drafting specific 'admission/welcome packs' for children and parents/carers.
5.2.3	The welcome pack should include: The complaints procedure; Who else has access to information that the young person shares with the services; Circumstances under which information may be disclosed or shared.	2	To my knowledge this isn't included in the preadmission pack. Not all of this is included. Parents liaise with the family therapist or psychologist weekly. Some of this information is usually provided verbally to children in the ward and may be documented as given/explained to them; however, it is not formally given in written form as a document. Children are continually verbally reminded of this information particularly by nursing staff as standard procedure. Currently, the unit is working on drafting specific 'admission/welcome packs' for children and parents/carers.
5.2.4	Staff members explain the main points of the welcome pack to the young person and ask if they need further information on anything explained.	2	Children are given an orientation and asked if they have any additional questions about the ward. Limited explanations are given. Parents are the ones who are engaged. The information is usually provided verbally by nursing staff at admission. Currently, the unit is working on drafting 'admission/welcome packs' for children and parents/carers.

Chronological Order of Unit Standards for Information, Consent and Confidentiality (Category 5) Continued

	Unit Standards	Mode	Qualitative Reasoning
5.2.5	Young people are given verbal and written information on: • Their rights regarding consent to care and treatment; • How to access advocacy services; • How to access a second opinion; • How to access interpreting services; • How to raise concerns, complaints and compliments; • How to access their own health records	2	Some of that is given verbally but not all of it and not in a written format to my knowledge. Some of this information is given verbally to children as part of the admission process. Currently, the unit is working on drafting 'admission/welcome pack' for children which will provide this information in written form developmentally/age appropriate language.
5.2.6	The team provides each carer with a carer's information pack. *Guidance: This may include the names and contact details of key staff members on the unit. It also includes other local sources of advice and support such as local carers' groups, carers' workshops and relevant charities.*	2	To my knowledge the information pack doesn't include that kind of information. Not all of the information suggested is available. Information pack is handed over during the initial assessment stage. Contains some of the information described in this standard.
5.2.7	There is evidence that information leaflets for parents/carers and young people have had involvement from parents/carers or young people in developing them.	1	The preadmission pack did, I believe, have some involvement from children in its planning. We're in the process of putting together leaflets and are including carers in that process. Appropriate but can be refined. There is no evidence.
5.3.1	Each young person is allocated key worker(s) and the young person and their parents/carers are told who this is.	3	As case manager in this regard. This is routinely done. Not all young people are aware who their key worker/case manager is. A special nurse and a case manager is allocated for the child even before admission. Done as standard practice. Children are particularly informed of whom their contact nurse is.
5.3.2	Staff updates parents/carers on their child's progress at a minimum of once a week, subject to confidentiality.	2	Patient notes. This is broadly done though perhaps not sufficiently that the criteria can be fully met Parents are seen weekly to discuss progress. Parents receive feedback from the allocated case manager, they also receive nursing staff feedback during Wednesday visits and when they collect their children for the weekend.

Chronological Order of Unit Standards for Information, Consent and Confidentiality (Category 5) Continued

	Unit Standards	Mode	Qualitative Reasoning
5.4.1	Staff members wear their Trust/ Organisation ID when working on the ward and this is easily visible.	2	From personal observation, not all staff routinely wear ID badges. Staff members are meant to wear these ID documents but don't always. They know about it but do not always wear it. Hospital issued name badges, National Core Standards Audits.
5.4.2	There is a board on display with the names and photographs of staff.	2	There was but it is not updated and currently broken. There is meant to be one but there currently is not one. Currently being updated. There is one that is not updated due to staff leaving due to retirement and resigning. The TLC staff name board with photographs is current being mended as it got damaged.
5.5.1	Young people and their parents/carers are informed verbally and in writing of their right to confidentiality and its limitations.	2	To my knowledge confidentiality in the ward is routinely discussed in the ward. They are not always informed in writing. This discussed on admission and whenever sensitive information is shared. This information is provided verbally, and documented in writing in the patient clinical and nursing notes.
5.5.2	Consent is sought prior to the disclosure of case material to parents/carers if the young person is assessed as able to make a decision. *Guidance: In certain circumstances this may be overruled if felt in the young person's best interests. The young person should be informed when this happens.*	3	Available through patient notes. This would be routinely done. I have no evidence that this happens. Ideally this process would be followed. It should be documented in the files but I have not seen it documented. Parents are assured and the kids to a certain extent. This information is provided verbally, and documented in writing in the patient clinical and nursing notes.

Chronological Order of Unit Standards for Information, Consent and Confidentiality (Category 5) Continued

	Unit Standards	Mode	Qualitative Reasoning
5.5.3	The young person's consent to the sharing of clinical information outside the clinical team is recorded. If this is not obtained the reasons for this are recorded.	2	Where relevant and appropriate this would be done. Certainly we would include carers in this process, given that many of the children we see are younger. I have not seen this recorded in the clinical notes although it may have been discussed with the patient. Not applicable. Children are under age. This information is provided verbally, and documented in writing in the patient clinical and nursing notes.
5.6.1	Consent is sought and recorded by staff. *Guidance: Where the young person is assessed as not having competency to consent then this should also be recorded. This applies to both medication and therapy and should be sought by staff members administering the treatment.*	1	To my knowledge this would mostly be done, again given the age of many of the children it is usually assent that is looked for and parents/careers are included and the thoughts recorded. Consent and or competency is not recorded. Consent is obtained from the parents due to patients' age. Medical and therapeutic treatment is explained and discussed to children who give verbal assent. According to the Children's Act, children may give consent for medical treatment from the age of 12 years old, thus they assent.
5.6.2	All young people's consent is recorded when a decision is required about their care. Where young people are not able to give consent, their views are ascertained as far as possible and taken into account. The legal basis for giving the proposed treatment or intervention is recorded.	1	I believe this is mostly done. This is not recorded. Consent is obtained from the parents due to patients' age. Medical and therapeutic treatment is discussed and explained to children who give verbal assent. According to the Children's Act, children may give consent for medical treatment from the age of 12 years old.
5.6.3	Staff informs young people both verbally and in writing of their right to agree to or refuse treatment and the limits of this.	2	I'm not sure this is always done in writing and I'm not clear it would always be relevant. Patients are informed about their rights verbally, but not in writing. Parents are consent is obtained from the parents due to patients' age. According to the Children's act, children 12yrs and older may give consent to the medical treatment. For younger children, verbal assent is obtained.

Chronological Order of Unit Standards for Information, Consent and Confidentiality (Category 5) Continued

	Unit Standards	Mode	Qualitative Reasoning
5.6.4	For all young people, the young person's capacity and/or competency is assessed and recorded when a decision is required about their care.	3	This would be done routinely to my knowledge. Competency is not assessed. As standard practice, developmental levels of functioning are usually assessed as part of psychiatric and psychological assessment. Additional psychometric and cognitive testing is done on a case by case basis. This informs the level, type (and support provided) of child participation in decision making processes.
5.6.5	Where young people are not able to give consent, their views are ascertained as far as possible and taken into account, and the legal basis for giving the proposed treatment or intervention is recorded.	3	This would be routinely done. I have never seen this recorded. According to the Children's act, children 12yrs and older may give consent to the medical treatment. For younger children, verbal assent is obtained. Verbally obtained assent is not consistently recorded. As standard practice, developmental levels of functioning are usually assessed as part of psychiatric and psychological assessment. Additional psychometric and cognitive testing is done on a case by case basis. This informs the level, type (and support provided) of child participation in decision making processes.

Chronological Order of Unit Standards for Information, Consent and Confidentiality (Category 5) Continued

	Unit Standards	Mode	Qualitative Reasoning
5.6.6	Assessments of young people' capacity (and competency for young people under the age of 16) to consent to care and treatment in hospital are performed in accordance with current legislation and documented in the young people' notes. When young people do not have capacity to consent, best interest processes involving professionals and family (where appropriate) are followed. These assessments should be undertaken at every point that a young person is required to participate in decision making.	3	This would best be answered by doctors. These are not routinely done in the ward. Consent form is in writing and explains consent. Parents are the appropriate people to negotiate with the doctor regarding a decision about the treatment process. According to the Children's act, children 12yrs and older may give consent to the medical treatment. For younger children, verbal assent is obtained. Verbally obtained assent is not consistently recorded. As standard practice, developmental levels of functioning are usually assessed as part of psychiatric and psychological assessment. Additional psychometric and cognitive testing is done on a case by case basis. This informs the level, type (and support provided) of child participation in decision making
5.6.6	Written information is given to parents/carers which contains information about consent and their rights, and the limitations of these.	2	I would need to check the information pack but I'm not sure how much information is in their regarding consents and rights etc. I am not aware of any written information explaining rights. An indemnity form and the video taping of group sessions consent form by student OT's is signed by the parent on admission. When parents do not give consent e.g., when they withdraw consent to hospital treatment, they are given information about consent and their rights, and the limitations of these. This is usually given verbally and documented in writing.

Chronological Order of Unit Standards for Information, Consent and Confidentiality (Category 5) Continued

	Unit Standards	Mode	Qualitative Reasoning
5.6.7	Parental responsibility is recorded in the young person's notes.	3	This is routinely done (e.g. on the front of the child's folder). It should be recorded. Where the guardian is a social worker, the external social worker's name should be recorded. Parent's details are taken on admission. As per social work section, this is done as standard practice.
5.6.8	Young people and carers are offered written and verbal information about the young person's mental illness. *Guidance: Verbal information could be provided in a 1:1 meeting with a staff member, a ward round or in a psycho-education group.*	3	Through parent meetings. As relevant and clinically indicated this would be done. No written information is given. The children are also often excluded from these discussions. There should be more active participation of the children. This is handed over during parent feedback following a case presentation. Through clinical and nurses notes, this is done as standard practice.
5.6.9	Young people have an assessment of their capacity to consent to admission, care and treatment within 24 hours of admission.	1	Because the children we see are mostly under 12 I'm not sure how relevant this is but the admission process would mean that they are aware and give their consent (certainly that their parents/carers give consent). Not done. Through clinical and nursing notes.
5.6.10	The team follows a protocol for responding to carers when the young person does not consent to their involvement.	1	This would have been discussed prior to admission for the most part - I'm not familiar with a written policy but certainly meeting with the relevant staff, carers and child would take place as needed. This is based on the Children's Act of 2005 and hospital policies. Done as standard practice.

Appendix H

Chronological Order for Unit Standards for Young People's Rights and Safeguarding Children (Category 6)

	Unit Standards	Mode	Qualitative Reasoning
6.1.4	Staff explains to the young person who their Nearest Relative/Named Person is and why this is relevant.	3	This would best be answered by nursing. They are brought in by their parents; care givers; or relatives. Children who get admitted to the unit generally know this information, as they are admitted with parental/carer and/or designated social services' consent. During the course of admission, children get re-oriented by staff should their mental illness result in impairment in this regard.
6.1.5	The young person's Nearest Relative/Named Person is recorded in the young person's notes.	3	Certainly the child's parent/carer (who had legal responsibility for the child) would be in the patient file. Contact details and names are recorded. Usually documented on initial interview. They are brought in by their parents; care givers; or relatives. Through clinical and nursing notes. Done as standard practice.
6.1.6	Information is given to the Nearest Relative/Named Person about their rights.	3	I am not sure this is done routinely. This is done routinely. Through clinical and nursing notes. Done as standard practice.
6.2.1	Young people are able to see a clinician on their own, although this may be refused in certain circumstances and the reasons why are explained.	3	From personal experience, this would be the case unless clinically indicated otherwise. Resident senior registrar sees them daily. Through clinical and nursing notes. Done as standard practice.

Chronological Order for Unit Standards for Young People's Rights and Safeguarding Children (Category 6) Continued

	Unit Standards	Mode	Qualitative Reasoning
6.2.2	Young people are asked for their preference of staff member to act as a chaperone for physical examinations. This is provided if feasible and if not the reasons for this are documented.	3	This is sometimes done (e.g. school or some hospital visits) though often cannot be accommodated because of staffing rosters. They are always at ease with the doctors and they are not forced to if they don't want to share or see the doctor, which is seldom. They always want to negotiate discharge. Dependent on the staff on duty, If the patient is uncomfortable for some reason this will be discussed within the MDT. The patients best interest are always taken in consideration. Nursing and clinical notes, Western Cape Department of Health Chaperone policy.
6.2.2	Staff members are able to access training or gather specific information about the mental health needs of young people from minority or hard-to-reach groups. This may include: • Black, Asian and minority ethnic groups; • Asylum seekers or refugees; • Lesbian, gay, bisexual or transgender people; • Travellers.	2	Staff development plans. There are occasional trainings in this area but they are rare and I don't think many TLC staff has the opportunity to attend. No specific training on any of these issues is offered. Not all staff has internet access. Application for training via skills development is not always approved. In-service training, DCAP academic meetings, external training are all available but not always utilised.
6.2.2	The ward has a designated equality champion.	1	Some have been on equity training but I'm not aware of an equity champion. Not designated. Represented by operational manager delegates.
6.2.3	The unit has procedures to ensure that young people's access to media (e.g. TV, DVDs, audio and the internet) is age appropriate.	3	There is very little opportunity for access to the internet for children though it may be that this is age appropriate if supervised. No procedures to ensure that access to this is age appropriate. Children's visual and audio material is always done under supervision. Made available through the ward therapeutic programme and classroom.

Chronological Order for Unit Standards for Young People's Rights and Safeguarding Children (Category 6) Continued

	Unit Standards	Mode	Qualitative Reasoning
6.3.1	Information provided on complaints assures young people and parents/carers that if they complain they will not be discriminated against and their care will not be compromised.	3	I would hope this is the case although in reality there is not really a working system regarding complaints. Complaints and complements are available. Not sure if this reassures parents /carers that they will not be discriminated against. Every staff is aware that this is standard procedure and that everyone has a right to dignity. Complaints and compliments policy, quality assurance policies and patient rights charter.
6.4.1	The team effectively manages young people violence and aggression. *Guidance: 1) Staff members do not restrain young people in a way that affects their airway, breathing or circulation; 2) Restrictive intervention always represents the least restrictive option to meet the immediate need; 3) Individualised support plans, incorporating behaviour support plans, are implemented for all young people who are known to be at risk of being exposed to restrictive interventions; 4) The team does not use seclusion or segregation other than for young people detained under the Mental Health Act (or equivalent); 5) The team works to reduce the amount of restrictive practice used; 6) Services report on the use of restrictive interventions to service commissioners, who monitor and act in the event of concerns.*	3	I would say we try for this but in practice it is very difficult to manage aggression and violence. Time out /seclusion and restraint may be used more frequently when there is inexperienced staff on duty. Timian training which focuses at effective handling of difficult patients is carried out weekly to share about difficulties encountered and how to improve on those. This is carried out by our resident psychologist. Communicated through the TLC behaviour management SOP, management of an aggressive patient policy and Timian training. Done as standard practice.
6.4.1	Young people who are involved in episodes of restrictive physical intervention, or compulsory treatment including tranquilisation, have their vital signs monitored by nursing staff in collaboration with medics and any deterioration is responded to.	3	This would best be answered by nursing. I am not sure how carefully they are monitored and if there is a protocol for recording and reporting of any changes in symptoms. Again this is dependent on experienced nursing who are not always present. Observations are done daily and any discrepancies are reported promptly. No seclusion - time out space. Evidence in vital signs chart, nursing notes and clinical notes.

Chronological Order for Unit Standards for Young People's Rights and Safeguarding Children (Category 6) Continued

	Unit Standards	Mode	Qualitative Reasoning
6.4.1	Staffs know how to prevent and respond to sexual exploitation, coercion, intimidation and abuse on the ward. *Guidance: Staff must consider whether sexual incidents that are said to be consensual have been the result of coercion, exploitation or where a person's capacity to consent may have been affected by her mental health. Where there is any doubt, the incident must be investigated. Links must be established with the police in serious untoward incidents and to child protection.*	3	This question may be related to adolescent wards and I'm not sure would be appropriate for a children's ward. Staff are not appropriately trained to manage this. Some new staff but this should form part of training. Any sexually inappropriate behavior is addressed and reported immediately to the MDT. Incident reports are filled in and a copy sent to nursing management. Parents are also called in to make them aware of the matter. Children's act, hospital policy, nursing notes and clinical notes - social work, RCWMCH Social work department standard operating procedures.
6.4.2	After any episode of control and restraint, or compulsory treatment including rapid tranquillisation, the team spends time with the young person reflecting on why this was necessary. The young person's views are sought and they are offered the opportunity to document this in their care record along with any disagreement with healthcare professionals.	2	I believe this is done on some occasion though often there isn't the space or time for the kind of reflection with the child that would be ideal. This is dependent on the level of experience of the staff. Children do not spend more than 3 minutes in time-out room; they can decide to stay longer if they want to, just in order to calm themselves down. They are also expected to apologize if someone was hurt or furniture was destroyed in the process. No seclusion - time out space. TLC Behaviour management policy, nursing notes and clinical notes. Done as standard practice.
6.4.3	After any episode of control and restraint, or compulsory treatment including rapid tranquillisation, the team makes sure that other young people on the ward/unit who are distressed by these events are offered support and time to discuss their experiences.	3	There are 'worry groups' that happen though not enough I would suggest warranting fully met. This is dependent on the level of experience of staff on duty at the time. A worry group is held and thoughts and feelings are discussed. Support is given throughout the incident to allay their anxiety and this is done in a safe place, away from the drama. TLC Behaviour management policy.

Chronological Order for Unit Standards for Young People's Rights and Safeguarding Children (Category 6) Continued

	Unit Standards	Mode	Qualitative Reasoning
6.4.4	Parents/carers are informed about all episodes of restraint within 24 hours. If for any reason this does not occur, reasons are documented in the young person's notes.	1	From personal experience, it's quite rare we use physical restraint (aside from physically taking a child to Time Out. Parents would generally be informed if there was that need though may not be within 24hours. I am not sure that parents are informed within 24 hours. If they are, this is not documented in the files. A worry group is held and thoughts and feelings are discussed. Support is given throughout the incident to allay their anxiety and this is done in a safe place. Nursing notes and clinical notes. Done as standard practice.
6.4.4	Individualised support plans, incorporating behaviour support plans, are implemented for all young people who are being managed through the repeated use of restrictive physical interventions. *Guidance: The support plans are developed using functional analyses/applied behaviour analyses to understand, manage and prevent incidents.*	2	We occasionally have more detailed behaviour plans though not routinely. We do try and individualize plans and goals for children. An attempt is made to achieve this although it is not always clear from the notes that this is done. These are discussed in the goals and strategy meeting. Nursing and clinical notes, TLC staff weekly meeting schedule - goals and strategies meeting. Done as standard practice.
6.4.4	Systems are in place to enable staff members to quickly and effectively report incidents. Managers encourage staff members to do this.	3	There are definitely systems in place and management do encourage staff to complete incident forms. Staff needs to be further encouraged to report incidents timeously. Attempts need to be made to see these as learning experiences rather than being defensive about possible errors. Staff should be openly encouraged to discuss incidents and LEARN from them. A punitive environment still exists amongst some professionals. These are discussed in the goals and strategy meeting. Completed adverse incidents forms, RCWMCH Adverse incident management standard operating procedure, and DCAP Operational management meeting minutes. Done as standard practice.

Chronological Order for Unit Standards for Young People's Rights and Safeguarding Children (Category 6) Continued

	Unit Standards	Mode	Qualitative Reasoning
6.4.5	The team audits the use of restrictive practice, including face-down restraint.	1	We do not formally audit this that I'm aware of. I have not seen an audit of restraint. We don t often retrain. Audits are done for timeout. We document these in the time-out sheet form. No seclusion - time out space. Evidenced in TLC time out records.
6.4.6	Staff members know how often young people are restrained and how this compares to benchmarks, e.g. by participating in multi-centre audits or by referring to their previous years' data.	1	We don't do any comparison with other units. No audits are available. No seclusion - time out space. Staff members know how often young people are restrained but are not always aware of how this compares to benchmarks.
6.4.7	The unit follows organisational policies for untoward occurrences and critical incident reporting. *Guidance: This includes the circumstances and justification of using restraint, and the recording of information after a restraint has occurred.*	3	We complete incident forms and follow those hospital procedures. Follow hospital guidelines but need to be more open to reflective practice. Children are put in time-out for 3 minutes at a time. Through behaviour management policy and adverse incident reports, Timian training.
6.5.1	It is recorded as to whether or not a young person has a child protection plan in place.	3	I'm not sure what the equivalent is in a South African context. Not always met. Through clinical notes, specifically social work. Done as standard practice.
6.5.2	The unit has a named child protection lead and staff knows who this is.	1	We don't do this. Role and job description of the TLC Social worker. Standard procedure.
6.5.3	The unit has policies and procedures which are compatible with LSCB (or local equivalent) guidelines, including the conduct of reviews and procedures for working together.	2	I'm not familiar with what LSCB is.

Chronological Order for Unit Standards for Young People's Rights and Safeguarding Children (Category 6) Continued

	Unit Standards	Mode	Qualitative Reasoning
6.5.4	Staff knows what to do if there are safeguarding concerns and who to contact, during and out of working hours.	3	I would think that most staff is aware of who to contact in those cases. Children's act, DCAP Form 22 record, RCWMCH social work department standard operating procedures, Department of Social Development referral pathways. Done as standard practice.
6.5.5	If a young person raises safeguarding concerns or someone else raises concerns about them, staff inform them of the process that will be followed by the unit and other agencies.	3	From personal experience and patient notes. I think that this is mostly done; I'm putting down partially because sometimes it doesn't happen as quickly as we would hope. This is reported to the social workers. Through clinical notes, specifically social work. Done as standard practice.
6.6.1	The local authority will be made aware if a young person remains on the unit for a consecutive period of 3 months (in line with section 85 of the Children Act 1989).	2	I'm not sure this is relevant here or what the equivalent would be. Not applicable in our setting. DCAP Form 22 records, Clinical notes - Social work. Done as standard practice.
6.6.2	The local authority is alerted if the whereabouts of the person with parental responsibility is not known or if that person has not contacted the young person.	3	In the rare cases where this happen we do contact the relevant organisation (e.g. DSD). DSD will be informed. DCAP Form 22 records, Clinical notes - Social work. Done as standard practice.

Appendix I

Chronological Order of Unit Standards for Clinical Governance (Category 7)

	Unit Standards	Mode	Qualitative Reasoning
7.1.1	Young people and their carers are given the opportunity to feed back about their experiences of using the service, and their feedback is used to improve the service.	2	From personal experience, this is not done routinely although informally this is done at discharge meetings and with children. They were asked to fill in ESQs but this no longer happens. I think we can improve on this. Verbal feedback is received from children and parents/carers. Written feedback in the form of complaints and compliments forms are completed by parents/carers at their will. Completion of specific child or parent/carer experience of service forms is not yet implemented.
7.1.2	Key clinical/service measures and reports are shared between the team and organisation's board, e.g. Findings from serious incident investigations and examples of innovative practice.	3	There are some spaces where this is done (e.g. operational meeting). Through TLC admin meeting minutes and review meetings. Done as standard practice.
7.2.1	A range of local and multi-centre clinical audits is conducted which include the use of evidence based treatments, as a minimum.	2	There are some audits (annual reviews) done but not multi-site. Peer audits and national core standards audits assess broad standards which include child and adolescent psychiatry - they are however not specific to the field.
7.2.2	There are dedicated resources, including protected staff time to support clinical audit within the directorate or specialist areas.	2	Audits are done by hospital staff on an annual basis. Not protected time. Peer audits and national core standards audits. Done as standard practice.
7.2.3	The team, young people and carers are involved in identifying priority audit topics in line with national and local priorities and young person feedback.	1	I'm not aware that this happens. No clinical audits done. Patients not involved. Currently, young people and carers are not involved in identifying priority audit topics.

Chronological Order of Unit Standards for Clinical Governance (Category 7) Continued

	Unit Standards	Mode	Qualitative Reasoning
7.2.4	Measures are in place to record and audit referrals, terminated referrals and waiting lists.	3	The head of unit keeps referral records. DCAP referral file and TLC referral file and waiting list. Records are kept as standard practice.
7.2.5	When staff members undertake audits they; • Agree and implement action plans in response to audit reports; • Disseminate information (audit findings, action plan); • Complete the audit cycle.	2	Clinical audits not done. National core standards reports are discussed at team meetings, audit recommendations and action plans are agreed and implemented.
7.3.1	The lead clinician for the service has operational responsibility to ensure that identified risks are acted upon.	3	It is not always possible to appropriately manage risk factors such as security, poorly trained staff. Identified risks are taken to the admin meeting and each member is given a task of seeing to each identified problem and give feedback regarding the progress. Time frames are also given to evaluate the situation. Risks are identified but repairs or recommendation are not attended to immediately due to financial constraints at RCWMCH. Meetings with the ward operational manager, hospital nursing managers and DCAP Head of Clinical Service. TLC admin meetings and crisis management meetings with the team/ relevant members of the team.
7.3.2	The organisation has a risk management strategy.	3	I believe we have a set of policies relating to risk management, although these are often being updated. Risk assessment is done on admission and is carried out weekly to evaluate the situation. DCAP management of psychiatric and medical emergency policies, management of a suicidal patient policy. Management of patient abscondment policy and CCTV policy. Risk assessment forms, adverse incident forms.

Chronological Order of Unit Standards for Clinical Governance (Category 7) Continued

	Unit Standards	Mode	Qualitative Reasoning
7.3.3	Staff members share information about any serious untoward incidents involving a young person with the young person themselves and their carer, in line with the Duty of Candour agreement.	3	I am not familiar with the Duty of Candour. Dependent on the incident, this will be discussed with the young person. TLC rules which the kids recite at intervals also take into account safety issues and a child is constantly reminded to adhere to these so as to keep themselves safe. Nursing and clinical notes. Nursing handover book and adverse incidents forms. Morning meetings, TLC Ward rounds and admin meetings. Done as standard practice.
7.3.4	Lessons learned from incidents are shared with the team and disseminated to the wider organisation.	3	I think we do try and share information about incidents though not sure that we always reflect on lessons learned as a team. This is improving. Lessons learnt are not always shared as well as they could be. These are also shared in different settings, i.e. at ward round; classroom; supervision and during Timian training. TLC admin meetings, DCAP ward rounds and Divisional meetings. Done as standard practice.
7.4.1	Managers ensure that policies, procedures and guidelines are formatted, disseminated and stored in ways that the team find accessible and easy to use.	3	I think for the most part the policies are available for staff to look at should they wish. They are not always easily available or disseminated. These are stored in files and in the operational manager's office. DCAP Operational meetings, RCWMCH Policy review committee meetings and TLC review meetings. Done as standard practice.

Chronological Order of Unit Standards for Clinical Governance (Category 7) Continued

	Unit Standards	Mode	Qualitative Reasoning
7.4.2	There is a written admission procedure, which includes procedures for emergency referrals.	2	The admission procedure is not clearly defined. There is not a written document which stated procedure for planned admission versus emergency admission. I think this can be clearly documented and be easily accessible. Children are admitted via OPD referral list. TLC admission procedure. Done as standard practice.
7.4.3	The team follows a protocol to manage informal young people who discharge themselves against medical advice. This includes: • Recording the young person's capacity to understand the risks of self-discharge; • Putting a crisis plan in place; • Contacting relevant agencies to notify them of the discharge.	1	This would not be applicable to us as the child in this case is not able to do that (only their carer could). The young person cannot discharge themselves but the parent/carer can. There is no policy that deals with this. Rare but we have policy in place. Parents and caregivers are consulted when patients verbalizes their unwillingness to care. Due to patient's age. This is not applicable.
7.4.4	There are policies and procedures on the management of aggression and violence and the use of physical restraint.	3	We have such a policy (documents). There are no clear policies on this. SOP on management of aggression and violence and the use of physical restraint. Done as standard practice.
7.4.5	There is an organisational policy for the use of rapid tranquilisation.	2	As I understand we do. There is document which discussed rapid tranquillisation in the EC. Not sure if written policy exists. TLC Chemical restraint policy. Done as standard practice.
7.4.6	There is a policy on clinical risk assessment and management.	3	While clinical risk assessment and management is performed there are no clear policies on what protocols should be followed. These are discussed in the goals and strategy meeting. Already discussed the issue, this is repetition! This is done as standard practice.

Chronological Order of Unit Standards for Clinical Governance (Category 7) Continued

	Unit Standards	Mode	Qualitative Reasoning
7.4.7	There is a policy for responding to serious incidents requiring investigation.	3	There is a clear policy for this (documents). Process of incident reporting. We have a resident social worker who attends to these issues, assisted by the MDT. This is done as standard practice
7.4.8	The unit has policy and procedures for the management of bullies and for those who have been bullied, which covers both staff and young people.	2	I'm not sure that there is a specific written policy on this though certainly we would have an informal set of processes to discuss and manage this. No bullying policies available. No written policy. Already discussed on behavioural issues. E.g. The never ever rules. This is done as standard practice.
7.4.9	There is a locked door policy which allows young people to be cared for in the least restrictive environment possible.	2	I'm not sure what a locked policy means or involves. No policy about locked door but the philosophy is to maintain the least restrictive environment. The door is kept locked at all times. This is done as standard practice
7.4.10	There are appropriate procedures where units close at weekends.	3	We do have policy documents for weekends. Parents /carers are informed what to do in an emergency. Patients go to the main hospital in cases of emergency and senior registrar on-call asses, stabilizes and will either admit or send back home depending on the patient's condition. TLC weekend SOP. This is done as standard practice.
7.4.11	There is a clear policy on young people's smoking.	1	DCAP Smoking policy. Applies to everyone. No smoking is allowed but I have not seen a policy on this. All patients under 12yrs Smoking policy – smoking on hospital property. Not applicable - children admitted to the TLC are under the legal age for smoking.

Chronological Order of Unit Standards for Clinical Governance (Category 7) Continued

	Unit Standards	Mode	Qualitative Reasoning
7.4.12	There is a policy on the use of mobile phones, including use of camera phones and internet enabled phones.	3	I know there is certainly an understanding about patients and phones. None of these are allowed but i have not seen a policy.
7.4.13	There is a policy on the use of the internet by young people on the unit.	1	I don't think we have a policy on this. No policy. No access to the internet. The hospital doesn't provide internet to service users.
7.4.14	There is a policy on the use of drugs and alcohol, and on the management of young people who may be abusing drugs and alcohol.	1	I'm not aware that we have this specific policy. No ward policy on drug use. Children under 12yrs – substance abuse policy are adhere to at the ward. Western Cape Department of Health guidelines on management of patients with substance abuse.
7.4.15	Staff members follow a protocol when conducting searches of young people and their personal property and visitors where necessary.	3	Staff routinely checks for dangerous items when patients are admitted and coming back from weekends or holidays. No protocol on search policies. Bags are checked routinely for any dangerous weapons and for food. Anything extra that the parent bring for the child needs to be handed over to the staff members. Done as standard practice as part of risk assessment and management.
7.4.16	The unit has a policy on the use of seclusion. *Guidance: If seclusion is not used, this policy should include how situations are managed when seclusion is needed.*	3	Again I'm relating this to time out (I'm not sure that is seclusion in the sense they're using?) where we do have a policy. There is time out policy. Same has already been discussed with Time-out policy. Time our policy, but the unit has a copy of the seclusion policy. Done as standard practice.

Chronological Order of Unit Standards for Clinical Governance (Category 7) Continued

	Unit Standards	Mode	Qualitative Reasoning
7.4.17	Staff members follow a lone working policy and feel safe when escorting young people on leave.	1	I'm not aware that we have a policy on this. No lone working policy. I think this is mostly true. Not sure what the standard is assessing; however, patients going on leave are fetched directly from the ward by parents/carers. Staff do not escort patients on leave.
7.4.18	The team follows a protocol for managing situations where young people are absent without leave.	2	We do follow a protocol, although I'm not sure this is written down somewhere. No protocol for managing children who AWOL. The unit has procedures to follow for patients absent without leave.
7.4.19	The team understands and follows an agreed protocol for the management of an acute physical health emergency. *Guidance: This includes guidance about when to call 999 and when to contact the duty doctor.*	3	I think that most staff member would know what procedures to follow. There is no written agreed protocol. This is dependent on nurses' training. there are notices advising what to do in an emergency and who to contact. Nursing management is informed including the senior registrar on call. Emergency numbers are also visible on the wall next to the phone. Patient's family is also informed. Management of a medical emergency policy. Done as standard practice.
7.4.20	The team follows an agreed protocol with local police, which ensures effective liaison on incidents of criminal activity/harassment/violence.	3	There has been some contact in my experience with local police; I'm not familiar with an agreed protocol. Only contact details for the police are available. there is no agreed protocol. Mowbray police station is available when needed. The unit has an agreed protocol with hospital security and local police.

Chronological Order of Unit Standards for Clinical Governance (Category 7) Continued

	Unit Standards	Mode	Qualitative Reasoning
7.5.1	The ward/unit is explicitly commissioned or contracted against agreed ward/unit standards.	3	I'm not aware of this. No contract. The unit is under the Western Cape Department of Health, it functions as designated by province.
7.5.2	Commissioners and service managers meet at least 6 monthly.	1	I don't know what the equivalent of commissioners is in this case? Not applicable for our service. I think so. Meetings are held regularly with hospital management.
7.5.3	The team reviews its progress against its own plan/strategy, which includes objectives and deadlines in line with the organisation's strategy.	3	This happens to some extent at the annual review although not always with specific deadlines and goals. I haven't been involved in any strategy meetings so can't comment further. There are regular ward reviews. Review meeting is held yearly. TLC review meetings. Done as standard practice.
7.5.4	The ward/unit has a meeting, at least annually, with all stakeholders to consider topics such as referrals, service developments, issues of concern and to re-affirm good practice.	2	We do have annual meetings but these don't include all stakeholders. This has not happened. This is incorporated in the review meeting. TLC review meetings. Done as standard practice.
7.5.5	Key information generated from service evaluations and key measure summary reports (e.g. reports on length of stay) are disseminated in a form that is accessible to all.	3	We have receive some summary reports from the annual review. This is not done. Reports on progress and discharge summaries are written on each patient. Clinicom statistics, TLC review meetings. Done as standard practice.
7.5.6	Young person representatives attend and contribute to local and service level meetings and committees.	1	This doesn't happen, not sure how relevant it would be in our case. Not applicable, patients are all under 12 yrs.