Leeds Community Healthcare NHS Trust

Child and adolescent mental health wards

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RY632	Little Woodhouse Hall	Leeds Child and Adolescent Mental Health Service (CAMHS) Adolescent In-patient Service.	LS2 9NT

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

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

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

Summary of findings

Ratings

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

Overall rating for the service

Are services safe?

Requires improvement 

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

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

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

Summary of findings

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Summary of findings

Overall summary

We only inspected the safe domain of Little Woodhouse Hall.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as requires improvement because;

- During this inspection new, additional ligature risks were identified. This meant there was opportunity for young people to harm themselves by ligaturing (hanging).
- The service did not comply with same sex accommodation guidance as defined in the Department of Health guidance for eliminating mixed sex accommodation.
- We found areas of the unit that were not clean and posed a further risk of exposure to infection.
- The unit did not have sufficient contingencies in place to allow the service to remain open when an outbreak of diarrhoea and vomiting had affected three staff members.

However:

- The required equipment and medication were available, accessible and being checked regularly.
- The staff members had alarms and knew how to respond to incidents and the number of staff on shift was adequate to meet the needs of patients.
- Patients had up to date risk assessments completed by a nurse and were involved in writing these and the assessments were reviewed regularly and after incidents.
- Patients could access a range of activities and escorted leave and this was facilitated by staff.

Summary of findings

Information about the service

Child and adolescent mental health services (CAMHS) deliver services in line with a four-tier strategic framework which is nationally accepted as the basis for planning, commissioning and delivering services.

Tier 1 - Consists of practitioners who are not mental health specialists, for example GPs, health visitors, school nurses, teachers, social workers, youth justice workers and voluntary agencies. Practitioners offer general advice and treatment for less severe problems, contribute towards mental health promotion, identify problems early in their development and refer to more specialist services.

Tier 2 – Consists of CAMHS specialists working in community and primary care settings. Practitioners offer consultations to identify severe or complex needs which require more specialist interventions and assessment.

Tier 3 –Consists of a community mental health team or clinic or child psychiatry outpatient service, providing a specialised service for children and young people with more severe, complex and persistent disorders.

Tier 4 –Consists of services for children and young people with the most serious problems, such as day units, highly specialised outpatient teams and in-patient units.

Leeds Community Healthcare NHS Trust is responsible for providing healthcare services in the Leeds,Yorkshire and the Humber region. The trust provides a range of community services for adults and children including community nursing, health visiting, physiotherapy, community dentistry, primary care mental health, Child and Adolescent Mental Health Services, smoking cessation and sexual health services. It has 3,000 staff that delivers a service to approximately 800,000 people a year.

Leeds Child and Adolescent Mental Health Service (CAMHS) offer assessment and specialist intervention to children and young people with significant emotional and mental health problems (e.g. anxiety, depression, eating disorders) and their families.

The most recent Care Quality Commission (CQC) inspection on the 25 November 2014 found Little Woodhouse Hall was in breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found patients were not protected against the risks associated with unsafe or unsuitable premises at Little Woodhouse Hall. Staff had not identified all the potential risks to patients from fixtures on the unit that could be used by them to self-harm by hanging. The trust had identified the premises were not suitable, but did not have a clear timescale for moving to new premises or how the present premises could be improved upon whilst they waited for the move. At this inspection, we found that some improvement had been made however, the trust still did not have a timescale for moving to new premises. Since the inspection took place, the trust have submitted further information which shows a timescale for moving premises has been identified.

Our inspection team

The team was comprised of: two Care Quality Commission Inspectors.

Why we carried out this inspection

We inspected this core service as a result of being notified of delays in the implementation of the trusts action plan and concerns with regard to incidents that had occurred at the service.

Summary of findings

How we carried out this inspection

This was an unannounced inspection.

During this inspection, we looked at the following key question:

• is it safe?

Before the inspection visit, we reviewed information we held about the service including statutory notifications sent to us by the trust. A notification is information about important events that the trust is required to send to us.

During the inspection visit the inspection team:

- visited Little Woodhouse Hall and looked at the quality of the environment
- spoke with the unit manager and the service manager
- spoke with four other staff members.

We also:

- looked at two treatment records of patients
- looked at staff rotas
- looked at policies
- carried out a specific check of the maintenance of the unit.

What people who use the provider's services say

We did not speak with any of the patients on the unit at the time of our inspection.

Areas for improvement

Action the provider MUST take to improve

The provider must ensure that all ligature points are identified and included on environmental risk assessments.

The provider must ensure that the environment is clean.

The provider must comply with eliminating mixed sex accommodation guidance. The provider must ensure that patients are offered the choice to access designated areas of the ward for single sex usage at all times.

Action the provider SHOULD take to improve

The provider should ensure that staff review language used to discuss and record searching. Terms stated in the relevant policy regarding personal searches of patients should be adopted.

Leeds Community Healthcare NHS Trust

Child and adolescent mental health wards

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Leeds CAMHS Adolescent In-patient Service.	Little Woodhouse Hall

Mental Health Act responsibilities

We did not include this in our inspection.

Mental Capacity Act and Deprivation of Liberty Safeguards

We did not include this in our inspection.

Requires improvement

Are services safe?

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

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

Summary of findings

- During this inspection new, additional ligature risks were identified. This meant there was opportunity for young people to harm themselves by ligaturing (hanging).
- The service did not comply with same sex accommodation guidance as defined in the Department of Health guidance for eliminating mixed sex accommodation.
- We found areas of the unit that were not clean and posed a further risk of exposure to infection.
- The unit did not have sufficient contingencies in place to allow the service to remain open when an outbreak of diarrhoea and vomiting had affected three staff members.

However:

- The required equipment and medication were available, accessible and being checked regularly.
- The staff members had alarms and knew how to respond to incidents and the number of staff on shift was adequate to meet the needs of patients.
- Patients could access a range of activities and escorted leave and this was facilitated by staff.
- Patients had up to date risk assessments completed by a nurse and were involved in writing these and the assessments were reviewed regularly and after incidents.

Our findings

Safe and clean environment

At the previous inspection on the 25 November 2014 found Little Woodhouse Hall was in breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found patients were not protected against the risks associated with unsafe or unsuitable premises at Little Woodhouse Hall. Staff had not identified all the potential risks to patients from fixtures on the unit that could be used by them to self-harm by hanging. The trust had identified the premises were not suitable, but did not have a clear timescale for moving to new premises or how the present premises could be improved upon whilst they waited for the move. At the time of this inspection we found that some improvement had been made, however, the trust still did not have a timescale for moving to new premises. Since the inspection took place, the trust have submitted further information which shows a timescale for moving premises has been identified.

The service did not comply with same sex accommodation guidance as defined in the Department of Health guidance for eliminating mixed sex accommodation. We saw that male patient bedrooms were located at the end of the same corridor as female bedrooms. This meant they had to walk past female bedrooms and bathrooms to get onto the main unit area. There was also a lack of evidence to show that patients were being offered a choice in terms of the provision of same sex areas such as lounges, as required in the CNO guidance Eliminating Same sex Accommodation. Whilst CAMHS units can be flexible in their approach to providing same-sex day-spaces, and may find that they are not wanted by patients in the unit, it is not acceptable to apply a blanket approach that assumes mixing is always excusable.

During our inspection, we toured all areas of the unit. We found some areas of the unit were unclean. Patient bathrooms had areas that required further cleaning. Some toilets were unclean and showers were grubby. We found one of the foot-operated bins was broken which would mean patients would need to lift the bin lid by hand, which is an infection risk. Doorframes had dirty marks on them, as did the underneath of sinks. Some light switches were dirty. Corridor paintwork was marked and due to the poor decorative order, in some places it was difficult to ascertain if they were clean.

Prior to our inspection there had been a staff outbreak of diarrhoea and vomiting so we were particularly interested in reviewing staff areas. During the outbreak, patients were sent home on section 17 leave to ensure they did not become unwell. The manager told us this was also because the service did not have staff numbers in place to ensure the running of the service. The external cleaning provider had carried out a deep clean of the unit but this did not meet with required standards. We found staff areas were still an infection risk. The staff toilet area had grime around

and under the sink. The staff kitchen was unclean, the top of the fridge was dirty and the seal at the back of the sink was stained and cracked. There was a notice stating that staff should use disposable cloths once and throw them away, we noted there was a cloth in the sink, which staff were reusing.

There was an area designated as a gym which staff told us had little use. However, the room had previously been used a children's soft play area and had padded walls. The padding in some places was coming away from the wall and the some of the plastic covering had split exposing the foam. This would be difficult to clean and was an infection risk.

There was a small lounge at the end of the patient corridor. Staff said patients could use it as a quiet lounge, however, the furniture in the room was in poor state of repair. One of the chairs was dirty. The lounge would not be a pleasant area to spend time.

We reviewed ligature risks throughout patient areas and found there had been some improvement since our last inspection. However, after reviewing the in-patient environmental risk' assessment, we found that staff had not identified all ligature risks. In patient toilets and bathrooms we found hand gel, hand towel dispensers, toilet seats and ceiling extractor fans were not anti-ligature. Some doors did not have anti-ligature hinges. Staff had not identified any of these risks on the ligature risk assessment. This meant we were not assured that patients were protected from the risk of self-harm by hanging.

In some areas of the unit, we found there were poor lines of sight. Staff were not able to see straight down the patient corridor as there was a 'dog leg' in the middle of the corridor. Staff told us that when they were not carrying on checks during the night they would sit in the patient lounge from which they said they would be able to hear if a patient had left their bedroom. However, we were concerned that this did not adequately protect patients during the night. We were also concerned during the day this would be a problem particularly as there would be a significant amount of noise. Staff said patient risk assessment and patient observation levels would mitigate these risks.

Most of the patient areas were on the first floor of the building. The main steps up to the patient areas had one area of damage, which had hazard tape on. We asked staff how long the step had been damaged and we were told it had been several weeks. We looked at the unit maintenance book and could not find where staff had reported this. However, the manager told us this was probably because the units external contractor had identified the damage. We reviewed the external contractor's maintenance policy and it stated that damage of this type should be resolved within 24 hours.

The clinic room was clean and tidy. Equipment was well maintained. Room and fridge temperatures were checked daily and were within recommended maximum and minimum levels. The room contained a physical examination bed with disposable covering. Patient medication stored in the fridge had dates of opening on them to ensure staff administered medication within recommended timescales. Resuscitation equipment and emergency drugs were stored in the main office. Staff checked it daily to ensure the resuscitation equipment was fully charged and working and emergency drugs were in date.

Medication cards we reviewed were complete and contained details of the patients mental health act detention status.

Safe staffing

During the day there was a minimum of two registered nurses and two healthcare assistants on duty. At night there were two qualified staff members and two healthcare assistants. These staffing levels were adequate to meet the needs of patients.

The number of staff members on duty did normally reflect the rota, but we were told by staff there were occasions when there were not the required number of staff on shift. We were told staffing levels were increased according to the needs of the patients being supported on the unit. This was managed this by using bank and agency staff.

The staffing levels were often maintained using bank and agency. Staff told us they 'block booked' agency staff to ensure consistency of care. Data we reviewed showed that for May 2016 bank staff usage covered 781.5 hours and agency staff usage covered 707 hours. The staff sickness record for the service was 5.59% at the end of May 2016.

Patients had access to regular leave and activities. Staff we spoke with told us planned leave was only cancelled when there was a change with the patient's presentation which would make it unsafe to take them out of the building. The records showed patients did receive regular leave. The

Requires improvement

Are services safe?

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

number of activities available on the unit, including a gym and outside sports facilities, were good and this enabled patients to increase their independence as part of their continued recovery.

Assessing and managing risk to patients and staff

Staff completed risk assessments for patients and regularly updated particular risks when identified. Management plans were put in place to support the patient and their family to manage the issues.

Care plans demonstrated an individualised approach was in place regarding restrictions. There was clear evidence in the two care records we reviewed which showed they had involved the patient. Decisions regarding restrictions and leave were agreed with the patient.

All staff had to complete training on physical interventions and this was refreshed on an annual basis. Staff had either completed the training or were booked to attend. Data we reviewed show there were 120 recorded incidents involving restraint in the six months prior to the inspection. These involved nine patients over a three month period. Staff told us prone restraint was not used on the unit. Staff we spoke with told us de-escalation would first be tried and restraint was always a last resort. Records we reviewed confirmed this.

The service is not required to have a seclusion room or a de-escalation area. Staff told us they would use quieter areas of the unit to support patients through the de-escalation process. If patients exhibited 'at risk' behaviours such as self harm or violence and aggression, staff told us they would implement the 'locked door policy and procedure'. This meant they would lock the doors of the unit to prevent the patient from leaving the unit.

We saw there was a policy of searching patients when they returned from leave. This measure was in place for the safety of the individual and other patients. There was a dedicated room for searching the patients. When we spoke with staff we were concerned about their use of language to describe searching patients. They used the term 'strip search' and we saw this was also used to describe searches in the records we reviewed. We reviewed the policy in place and found this term was used for a practice of 'personal search' which the policy supported. There were restrictions on the items patients could have access to with some banned articles and again this was due to the level of risk.

Staff were trained in safeguarding and policies and procedures were easily accessible in the nurses office. Safeguarding incidents were communicated at handover meetings or earlier. The social worker is part of the multi - disciplinary team and had a clear role where there were safeguarding concerns and worked jointly with clinicians in these circumstances.

Track record on safety

The Trust reported there had been no serious untoward incidents in the 12 month period prior to the inspection.

Reporting incidents and learning from when things go wrong

All staff were expected to take responsibility for reporting incidents. Staff reported incidents on the trust's electronic reporting system and gave appropriate examples of doing so. Reports were sent to the unit manager and trends were identified. These were discussed at the multi-disciplinary team meeting, leadership meetings and handover meetings.

The service had a structure for reporting incidents, investigating and cascading the information for managers to share with staff. Staff members received full support after a serious incident, including seeking medical advice if needed, a debrief meeting and opportunities for reflective practice in team meetings. Incidents were mainly low impact with no serious untoward incidents reported in the 12 months prior to the inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12.—(1) Care and treatment must be provided in a safe way for service users. 2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include (a) assessing the risks to the health and safety of service users of receiving the care or treatment; (b) doing all that is reasonably practicable to mitigate any such risks; (d) ensuring that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way; The provider must ensure that all ligature points are identified and included on environmental risk assessments. The provider must ensure that the environment is clean.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect 10.—(1) Service users must be treated with dignity and respect. (2) Without limiting paragraph (1), the things which a registered person is required to do to comply with paragraph (1) include in particular (a) ensuring the privacy of the service user; The provider must comply with eliminating mixed sex accommodation guidance.