

## Lancashire Care NHS Foundation 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)
RW5EE	Preston Royal Hospital	The Platform	PR2 9HT
RW5X7	The Junction	The Junction	LA1 4PW

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

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

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

# Summary of findings

## Ratings

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

### Overall rating for the service

Good 

Are services safe?

Requires improvement 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Good 

### **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 rated child and adolescent mental health inpatient wards as good because:

- Motivated and supported patients with care, dignity and respect, so patients felt supported and described positive relationships.
- Involved patients and their families in decisions and had access to good information to make these decisions.
- Comprehensively assessed patients' needs, included consideration of clinical needs, mental health, physical health and well-being and involved patients in developing their own care plans
- Held multi-disciplinary staff meetings to discuss and review patients' needs, to make sure patients received the best possible coordinated care and treatment.
- Offered patients activities and education.
- Monitored patients' physical healthcare, with links to GP surgeries to respond to any continuing physical health needs.
- Planned for discharge from admission (and discharge was rarely delayed).
- Used a systematic approach to discharge, using routine outcome measures to measure patients' progress and time their discharge process.
- Implemented best practice guidelines – such as routine outcome measures to plot patients' progress and experience (and had taken part in Royal College of Psychiatrists' Quality Network for Inpatients (QNIC) reviews).
- Gave patients the opportunity to give feedback about the service and listened to that feedback.
- Told patients how to raise a complaint or concern, and had investigated and responded to concerns and complaints.
- Reported, investigated, and responded to ward incidents, using clear processes to safeguard young people.
- Assessed the number of child and adult beds available in the trust, and responded to this by increasing beds and at times placing patients in adult wards to ensure they received the care and treatment they needed promptly.

However we also found that staff were:

- Staff at the Platform described secluding patients in an extra care area, but they had not followed the Mental Health Act code of practice guidance of what actions to take when secluding a patient. For example, one seclusion record out of the five reviewed had no evidence of who started and who ended seclusion. Three records did not have 15-minute recordings of the patient's progress. There were medical reviews in some records but it was unclear when the medical review took place. The Mental Health Act code of practice guidance helps protect patients' rights and ensures patients detention is lawful.
- Information provided by the trust demonstrated poor compliance with annual staff appraisals by teams. An annual appraisal enables the staff to review staff competency and ensure their development at work. In addition, at the Junction compliance with clinical and management supervision was low. Clinical supervision enables the managers to assess the quality of staff's work.
- Staff told patients detained under the MHA 1983 their rights and gave access to an advocate. However, at the Junction staff did not know the agreed and allowed medication under the MHA. This meant staff that may administer medication not permitted under the MHA.
- We found the ward action plan resulting from the health, safety and environmental audit at the Platform did not include the impending changes to the environment and was unclear about when actions would be completed. Following two patients attempting to harm themselves by hanging using fixed points in the lounge ceiling where they could attach something.
- Staff had completed their basic and intermediate life support skills but one member of staff was unconfident about using the handled suction machine. Also, some equipment in the clinic room had passed the expiry date for use.

# Summary of findings

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

### Are services safe?

We rated safe as requires improvement because:

- Staff had not fully protected patients when they followed the MHA code of practice or their own policy on seclusion, and records were unclear at the Platform. Staff described secluding patients in the extra care area but one seclusion record out of the five reviewed had no evidence of what member of staff started and ended the patient's seclusion. Three patients' records did not have 15-minute recordings of the progress of the patient.
- The garden at the Junction was only accessible to all patients when accompanied by staff. (A train line runs parallel to the garden and the barrier was insufficient and compromised patient safety). In addition, due to the risk of fixed ligature points in the ceilings, at the Platform, in communal rooms, some patients could not use the rooms without a member of staff.
- We found the ward action plan resulting from the health, safety and environmental audit at the Platform did not include the impending changes to the environment and was unclear about when actions would be completed. Following two patients attempting to harm themselves by hanging using fixed points in the lounge ceiling where they could attach something.
- Staff had completed their basic and intermediate life support skills but one member of staff was unconfident about using the handled suction machine. Also, some equipment in the clinic room had passed the expiry date for use.

However we also found that:

- Staff were suitably trained and flexible in their working arrangements, thereby ensuring the staffing establishment was sufficient to meet the needs of patients and keep them safe.
- Staff undertook a risk assessment of every patient on admission and updated this regularly and after any changes to the patient's needs
- Clear processes were in place to safeguard young people and staff knew about these.
- Staff had reported and investigated incidents, and learnt from them.

Requires improvement



### Are services effective?

We rated effective as good because:

Good



# Summary of findings

- Patients had comprehensive assessments of their needs, which included consideration of clinical needs, mental health, physical health and well-being.
- Staff involved patients in the development of their care plans.
- Staff monitored patients' physical healthcare. The wards had links with GP surgeries that responded to any continuing physical health needs of patients.
- Staff had implemented best practice guidelines. Staff used routine outcome measures to plot the patient's progress.
- The Junction had taken part in the Royal College of Psychiatrists' Quality Network for Inpatients CAMHS(QNIC) reviews.
- Staff had the necessary qualifications and skills to carry out their roles effectively.
- To make sure patients received the best possible coordinated care and treatment staff held a variety of multi-disciplinary meetings to discuss and review patients' needs.
- Staff felt supported and supervised. However information demonstrated poor compliance with annual appraisal by teams and only 69% of staff had clinical supervision from 1 September to 31 December 2014 at the Junction.
- Patients detained under the Mental Health Act 1983 had been informed of their rights and had access to an advocate. However, at the Junction staff had a lack of knowledge regarding agreed and allowed medication under the MHA.

## Are services caring?

We rated caring as good because:-

- Motivated staff supported patients with care, dignity and respect.
- Patients felt supported and described positive relationships with the staff.
- Patients and their families were involved in decisions and had access to good information in order to make these decisions.
- Patients had the opportunity to provide feedback about the service and staff listened to the feedback.
- Staff had good relationships with patients' families. For example, two parents who work in partnership with staff at the Junction and the Platform had received the National NHS England Participation award.

Good



## Are services responsive to people's needs?

We rated responsive as good because:-

Good



# Summary of findings

- Staff planned for patients' discharge from admission and patients' discharge was rarely delayed. The staff used a systematic approach to discharge, employing routine outcome measures to measure the patients' progress and timing of their discharge.
- Patients had the opportunity to take part in activities and education.
- Patients knew how to raise a complaint or raise a concern. Staff had investigated and responded to concerns and complaints in a timely way. Improvements were made to the quality of care because of a complaint.
- Information about the service was available and displayed on ward noticeboards.
- Patients had access to interpreters. Information about how to complain was in available for patients whose first language was not English.
- Staff assessed the number of child and adult beds available in the trust, and responded to this by increasing beds and at times placing patients in adult wards to ensure they received the care and treatment they needed promptly.
- Patients had access to wards that offered comfort and dignity.

## Are services well-led?

We rated well-led as good because:

- Managers had systems in place to monitor the performance of the wards and to review any risks to the patients' experience.
- Staff described good teamwork, displayed compassion, respected and showed dignity to patients and this reflected the trusts vision and values.
- Staff described a clear management structure and visible managers. Staff knew the senior managers in the trust.
- Staff felt supported and morale was good and said they felt confident to raise any concerns.
- To improve wards, the children's and families network service had a specific operational plan for 2015 to 2016 for CAMHS. This included a review of the weakness, strengths, opportunities, and threats of the CAMHS tier three and four services.
- Staff had shown innovation and good practice when encouraging families to participate in the service. They had participated in QNIC to drive improvements in the service.

However, we found areas where the trust must or should improve.

Where:

- Staff had not adhered to the MHA Code of Practice in respect of seclusion.

Good



# Summary of findings

- The ward action plan resulting from health, safety and environmental audit was unclear regarding the fixed ligature points on the ceiling at the Platform.



# Summary of findings

## Information about the service

Child and adolescent mental health services (CAMHS) deliver services in line with a four-tier strategic framework that is nationally accepted as the basis for planning, commissioning and delivering services. Tier 4 services are for children and young people with the most serious problems, such as day units, highly specialised outpatient teams and in-patient units.

Lancashire Care NHS Foundation trust child and adolescent mental health services (CAMHS) had two inpatient wards for children and adolescents

The Junction provided inpatient accommodation for eight mixed sex young people between the ages of 12 and 16 years. The Junction provides assessment or medical treatment for persons detained under the 1983 Act, caring for people whose rights are restricted under the Mental Health Act.

The Platform provided inpatient accommodation for six mixed sex young people aged 16 -17 years from across Lancashire who can no longer be safely and effectively managed in their own home/community setting. The service accepted admissions for young people experiencing acute mental health symptoms and could be accessed 24/7 following assessment by the crisis resolution and home treatment team.

The most recent Mental Health Act (MHA) monitoring visits took place at the Junction on the 14 December 2014 and the Platform 23 October 2013. We found issues relating to the MHA on these visits. The trust provided an action statement telling us how they would improve adherence to the MHA 1983 and the MHA Code of Practice.

## Our inspection team

Our inspection team was led by:

**Chair:** Peter Molyneux: Chair of South West London and St George's Mental Health NHS Trust.

**Team Leader:** Sharon Marston, Inspection Manager, Care Quality Commission (CQC).

**Head of Inspection:** Jenny Wilkes, Head of Inspection for Mental Health, Care Quality Commission (CQC).

The inspection team comprised of CQC inspectors; a consultant psychiatrist, a Mental Health Act reviewer and three nurse specialists in child and adolescent mental health services.

## Why we carried out this inspection

We inspected this core service as part of our on-going comprehensive mental health inspection programme.

## How we carried out this inspection

To get to the heart of the experience of people who use services' we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?

- Is it responsive to people's needs?
- Is it well-led?

Before the inspection visit, we reviewed information that we held about these services and asked a range of other organisations for information.

During the inspection visit, the inspection team visited both wards and looked at the quality of the ward

# Summary of findings

environment and observed how staff were caring for patients. We visited the Platform on the 28 and 29 April 2015. We visited the Junction on the 29 April 2015. We spoke with eight patients who were using the service, spoke with the ward managers and service manager for each of the wards, spoke with 16 other staff members, including consultant psychiatrists, clinical leads, qualified nurses, pharmacist, psychologist, social worker, speciality doctor, support workers and teachers, and we

attended and observed two hand-over meetings, and a multi-disciplinary team meeting (MDT). We collected feedback from four patients using comment cards, looked at 11 patients records and carried out a specific check of the medication management at the Platform and Junction, we also looked at a range of policies, procedures and other documents relating to the running of the service.

## What people who use the provider's services say

The majority of patients we spoke with at the Junction said they felt safe and that admission had helped them. They were aware of their rights under the MHA and all had been involved in their care planning. However, four patients said that activities did not always take place and

two patients stated they would like more access to online media and social positive comments about their care and treatment. The patients felt the ward was relaxed. All patients welcomed opportunities available to get off the ward and they said staff supported them to do this.

## Good practice

- The Crew is a Lancashire-wide group for young people, parents and carers (whose family use the service) who

have previously used the acute inpatient mental health service. The group works in close partnership with parents, management and commissioners in respect of service development and improvements.

## Areas for improvement

### Action the provider MUST take to improve

The trust must ensure that:-

- staff adhere to the Mental Health Act code of practice when secluding patients.

### Action the provider SHOULD take to improve

- The trust should make sure that:
- there is a clear action plan regarding the fixed ligature points on the ceiling at the Platform.

- all staff are confident to use the res-q-vac handheld vacuum suction machine.
- monitoring systems are put in place to ensure the clinic room equipment is regularly checked
- all staff adhere fully to the MHA code of practice and are specifically aware of the approval and agreement for administration of medication, at the Junction.
- all staff assess patients individual needs when deciding whether they can use communal rooms at the Platform or the garden area at the Junction.

## Lancashire Care NHS Foundation Trust

# Child and adolescent mental health wards

## Detailed findings

### Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
The Platform	Preston Royal Hospital
The Junction	The Junction

### Mental Health Act responsibilities

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

At the time of the visits, two young people were detained under the MHA at the Junction and one at the Platform.

We found that staff informed patients about their rights under the MHA. Information was available to young people in a friendly format in the welcome pack. This included their right to have their detention explained regularly and about the independent mental health advocacy service (IMHA). Patients described contact with the IMHA as helpful during care and treatment review meetings.

We reviewed the MHA documentation at the Platform for one patient, and found it all in order. The patients

confirmed that they knew their rights under the MHA and said that staff revisited this every month. In addition, they had also utilised their right of appeal against their detention. However we looked at one patient's MHA documentation at the Junction and found that the records were difficult to find and not always accurate. For example, the transfer MHA paperwork for was not readily available on the ward. Also, in the notes reviewed there was confusion regarding which section 17 leave form was the most up to date and in use. This prescribes how often leave has been agreed for the patient.

All staff had completed the mandatory online training on the MHA and their knowledge of the MHA was reasonable. However some staff we spoke with were unclear about the administration of medication under the MHA.

# Detailed findings

## Mental Capacity Act and Deprivation of Liberty Safeguards

The Mental Capacity Act (MCA) does not apply to young people aged under 16. For children under the age of 16, the young person decisions making ability is governed by Gillick competence. The concept of Gillick competence recognises that some children may have a sufficient level of maturity to make some decisions themselves.

Consequently, when working with children, staff should be assessing whether or not a child has a sufficient level of understanding to make decisions. The Mental Capacity Act does apply to young people aged 16 and 17.

Staff we spoke with had an informed knowledge about the MCA. Information from the trust showed all of the staff at the Platform and most at the Junction had completed training about the MCA.

The information pack given to patients, included information about consent, and advocacy services. Patients we talked with described providing consent to their care and treatment. For example, when and how often they could have escorted leave from the wards.

# Are services safe?

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

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

## Summary of findings

We rated safe as requires improvement because:

- Staff had not fully protected patients when they followed the MHA code of practice or their own policy on seclusion, and records were unclear at the Platform. Staff described secluding patients in the extra care area but one seclusion record out of the five reviewed had no evidence of what member of staff started and ended the patient's seclusion. Three patients' records did not have 15-minute recordings of the progress of the patient.
- The garden at the Junction was only accessible to all patients when accompanied by staff. (A train line runs parallel to the garden and the barrier was insufficient and compromised patient safety). In addition, due to the risk of fixed ligature points in the ceilings, at the Platform, in communal rooms some patients could not use the rooms without a member of staff.
- We found the ward action plan resulting from the health, safety and environmental audit at the Platform did not include the impending changes to the environment and was unclear about when actions would be completed. Following two patients attempting to harm themselves by hanging using fixed points in the lounge ceiling where they could attach something.
- Staff had completed their basic and intermediate life support skills but one member of staff was not confident about using the handled suction machine. Also, some equipment in the clinic room had passed the expiry date for use.

However we also found that:

- Staff were suitably trained and flexible in their working arrangements, thereby ensuring the staffing establishment was sufficient to meet the needs of patients and keep them safe.
- Staff undertook a risk assessment of every patient on admission and updated this regularly and after any changes to the patient's needs

- Clear processes were in place to safeguard young people and staff knew about these.
- Staff had reported and investigated incidents, and learnt from them.

## Our findings

### Safe and clean environment

Many patients on the ward attempted self-harm by hanging (ligature). From incident records, between November 2014 and April 2015, we noted there had been 37 incidents at the Platform and 36 incidents at the Junction of self-harm involving some form of ligature. We observed several potential ligature points at the Platform. Staff informed us that they used risk assessment and observations to reduce against these risks to patients. Also, doors were locked to prevent patient access to rooms that had any potential risks.

There were incidents on the 9 March and on 11 April 2015 at the Platform, where patients attempted self-harm from a fixed point in the lounge ceiling. We reviewed the documentation relating to ligature and environmental audits dated 12 November 2014. The audits had identified ceiling ligature risks in November. The subsequent action plan stated that patients should not be in the rooms without a member of staff present. The ward manager said the trust was looking to improve observation in the room, but confirmed that the building had loose ceiling tiles in other areas of the building where patients were unobserved. Staff had included the potential risk of ligature points to patients in the risk registers. However, the ward action plan resulting from health, safety and environmental audit, dated 12 November 2014, did not include the changes to the environment and was unclear about when the actions would be completed.

Staff managed most other risks to patients locally by appropriate changes to the levels of observation when they assessed patients to be at risk of self-harm. However we saw some areas in the bedrooms where patients could not be easily seen through the vision panel. The management informed us that staff would enter the bedrooms to check on the patients who were at risk.

# Are services safe?

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Neither ward had a seclusion room. However both had an area described as an 'extra care area'. Staff said that patients had not used the extra care area at the Junction in the last twelve months. However, at the Platform we found staff had used the extra care area to effectively seclude patients.

At the Platform, the extra care area resembled a seclusion area and did not promote the dignity and privacy of the patient. The bedroom connected to the lounge with a door that did not lock, the shower room and toilet opened into the lounge and did not have a door but a shower curtain. The environment was sparse and resembled a seclusion area. For example, there was a blue fire retardant mattress. The door to the entrance of the extra care area was lockable and the corridor door that led to the entrance of the extra care area was lockable. Staff told us that if patients used this area, two members of staff would attend at all times and if risk determined they would prevent patients from leaving the area.

The buildings were clean and staff followed good practices for the control and prevention of infection. Staff practice was supported by training; the Junction had 85% and the Platform 96% compliance with infection control training. Patient led assessments of the care environment, scored 98.2% for cleanliness and 92.4% for maintenance. In addition, cleanliness was monitored using the trusts' quality, safety, experience, effectiveness, and leadership.

The Junction and Platform complied with guidance on same sex accommodation. Both had en-suite bedroom facilities and separate male/female lounges could be provided if required.

There was no nurse call system at the Junction but there was a nurse call system at the Platform in the bedrooms.

Resuscitation equipment was available in the clinic room and regularly checked by staff. Compliance with intermediate life support was 100% for both wards and basic life support training for the Junction was 87 % and the platform 100%.

At the Platform, a res-q-vac handheld vacuum suction machine was available for use. Although training had been provided, we found one member of staff was not confident about using it and had to ask for the assistance of another who was able to assist.

In addition, we found out of date equipment in the clinic room. For example one airway, one syringes, one cannula and four blood containers.

## Safe staffing

The information that we gathered from staff and records demonstrated staffing establishments (levels and skill mix) were set and actively reviewed to keep patients safe and meet their needs. The ward managers were able to adjust staffing levels to support patient need and a qualified

The Platform had an establishment of 14.7 full time equivalent (FTE) qualified nurses and 12.2 FTE support assistants. The staff sickness rate in the last 12 months was low at 3.4%, which was below trust overall figure for sickness. The ward had vacancies of one qualified member of staff. Staff turnover was 6.5%. The data reflected this in the trusts' use of bank staff with only 40 out of 840 shifts filled. Only 12 vacant shifts out of 840 had been unfilled.

Staff at the Platform worked 12-hour shifts. In the morning the ward had two qualified nurses and three support workers. At night this was reduced to two qualified nurses and two support workers. In addition, one member of staff worked a twilight shift from midday to midnight. We reviewed three weeks of staff rotas that confirmed these numbers.

The ward had a multi-disciplinary team that comprised of a locum psychiatrist for 0.8 FTE and a full time specialist registrar and a psychologist for 0.4 FTE, a social worker 0.5 FTE and education staff. However, the ward did not currently have an occupational therapist.

The Platform had good compliance with mandatory training in relation to safeguarding children level 1, vulnerable adults, conflict resolution, equality and diversity and health and safety.

The Junction had an establishment of 12.4 full time equivalent (FTE) qualified nurses and 12.9 FTE support assistants. Staff sickness rate in the last 12 months was 7.8%, which was above the overall trust figure of 6.8%. The ward had vacancies of one qualified member of staff and one nursing assistant. Staff turnover was high at 13.9%. However, use of bank staff was low, where 70 out of 756 shifts filled and 15 shifts out of 756 had been unfilled.

Staff at the Junction worked 12 hour shifts, in a morning. And night time the ward had at least two qualified nurses



# Are services safe?

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and two support workers. In addition, one member of staff worked a twilight shift from midday to midnight. We reviewed three weeks of staff rotas that confirmed these numbers.

The ward had a multi-disciplinary team that comprised of a full time consultant, a full time speciality doctor, a full time psychologist and a part time creative psychotherapist 0.5 WTE. A clinical assistant 0.2 WTE, an occupational therapist for 0.6 WTE, a dietician 0.4 WTE, a social worker 0.5WTE, and a family therapist 0.4 WTE. Two life skills workers and a range of education and teaching staff.

The Junction had good compliance with mandatory training. For example in relation to safeguarding children level 1 and 2, conflict resolution, equality and diversity and mobility assistance at 100%.

Both wards rarely used agency staff, vacant shifts were filled with permanent staff working overtime or bank staff who knew the wards well.

Out of normal working hours, both wards relied on the junior psychiatrist on the Lancaster psychiatry rota for cover. At the Junction the junior psychiatrist was supported by a CAMHS consultant but at the Platform this was a consultant who normally cared for adults. However, the staff told us that plans were in place for the CAMHS psychiatric consultants to take this over so patients always received treatment from a consultant with the appropriate experience and skills.

## Assessing and managing risk to patients and staff

Staff had not adhered to the MHA code of practice or followed their own policy regarding seclusion. Information provided by the trust showed that staff secluded patients seven times at the Platform between 1 August 2014 and 11 February 2015 and no seclusion had taken place at the Junction. However, staff called this extra care and described secluding patients in the extra care area. It was clear from records that the patient was not free to leave and there was reference in the records to the use of arm holds to prevent a patient leaving. Staff did complete the seclusion paperwork but did not adhere fully to the seclusion policy. For example:

- One seclusion record out of the five reviewed had no evidence of who started and who ended seclusion.
- Three records did not have 15-minute recordings of the progress of the patient.

- Medical reviews were evident in some records but it was difficult to ascertain who independent reviewer was and when the medical review took place.

Data provided by the trust showed between August 2014 and February 2015 staff had not used physical restraint at the Junction. At the Platform staff used restraint 34 times, seven incidents of restraint in face down (prone position) and three with the use of rapid tranquilisation. The trust had formally adopted the reducing restrictive practices (RRP) programme as a two-year strategy to reduce restrictive practices in December 2014. When we spoke with the staff all described using least restrictive practices when supporting patients. In addition, the children and families network in February 2015 had undertaken a scoping exercise to review the use of restraint, and staff training to reduce the use of restraint.

We looked at 11 patient records and found most staff had effectively assessed and managed risks to individuals on admission and following any incidents. These included physical health and risks of harm to self and or others. Where possible, staff involved patients and their families in risk assessments that were person-centred and reviewed regularly. Staff used a risk based approach: this included comprehensive risk assessments and associated intervention plans.

However, staff had restricted some patients who they had deemed at risk at the Platform from using some communal rooms unless they were accompanied by staff. Due to the loose ceiling tiles and risk of fixed (ligature) points in the ceilings at the Platform. In addition, the garden at the Junction was only accessible to all patients when accompanied by staff. (A train line runs parallel to the garden and the barrier was insufficient and compromised patient safety.).

At the two handovers, we observed clear discussion amongst multi-disciplinary team (MDT) members of the current presentation of the patients' risk assessment, management of risks and any outstanding tasks requiring action.

There is a trust search and observation procedure in place. Patients said that staff described search procedures to them on admission and this was included in the comprehensive admission pack.

Staff completed training in safeguarding at levels two and three, and knew how to make safeguarding alerts. Both

# Are services safe?

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

wards had nearly 100% compliance in safeguarding level 1 and 2 training. Staff undertook safeguarding supervision every two months. The trust had a safeguarding performance framework, designed to support and provide evidence of engagement with safeguarding processes. This provided an overview of the training and safeguarding engagement by staff for senior management to monitor and review. The Trusts safeguarding annual report for 2013/2014 stated the Trust had contributed to eight children's serious case reviews (SCR). The wards had reported four safeguarding incidents from November 2014 to April 2015. Lessons learnt from incident reporting was fed back fortnightly to the team.

Medicines were stored securely and safely and administered by trained staff. The pharmacist had weekly meetings with the medical team and a pharmacy technician visited weekly. At the time of the inspection, medicines were dispensed from Lancaster Royal Infirmary, out of hours dispensing and pharmacist support was good. Although one doctor said that medicine, management particularly on discharge was sometimes difficult and caused delays. Plans were going ahead to start dispensing medicines at the Junction from June 2015, policies were being drawn up to support this transition.

## Track record on safety

There had been four incidents classified as level three (moderate) occurring at the Platform from November 2014 to April 2015, three of which related to ligature incidents. There had been nine incidents classified as level three (moderate) occurring at the Junction from November 2014

to April 2015. One incident at the Junction was classified as severe with a patient harming himself or herself whilst on leave. The ward manager provided information to show significant learning from the two of the incidents.

## Reporting incidents and learning from when things go wrong

Incident recording and reporting was effective and embedded across all wards. The trust used web-based patient safety computer software for healthcare risk management. This enabled staff to report, collate, monitor and analyse incidents. All of the staff we spoke with knew how to report incidents using the system.

Ward managers were reviewed the incidents recording and any lessons learnt fed back to the staff team at fortnightly meetings. The trust had a trust newsletter 'Green Lights' that managers emailed to all staff and printed off for those with little access to IT systems. Staff we spoke with told us about lessons from serious incidents in the trust.

From incident records, we noted that there had been 37 incidents at the Platform and 36 incidents at the Junction of self-harm involving some form of ligature from November 2014 to April 2015.

Staff had an awareness of the duty of candour. Information about duty of candour had been cascaded to team leaders in governance meetings. The team talk also provided staff with learning from incidents and transparency. In January 2013, the team talk included recommendations from an enquiry regarding the need for openness when responding to complaints.



# Are services effective?

Good 

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

## Summary of findings

We rated effective as good because:

- Patients had comprehensive assessments of their needs, which included consideration of clinical needs, mental health, physical health and well-being.
- Staff involved patients in the development of their care plans.
- Staff monitored patients' physical healthcare. The wards had links with GP surgery's that responded to any continuing physical health needs of patients.
- Staff had implemented best practice guidelines. Staff used routine outcome measures to plot the patient's progress.
- The Junction had taken part in the Royal College of Psychiatrists' Quality Network for Inpatients CAMHS(QNIC) reviews.
- Staff had the necessary qualifications and skills to carry out their roles effectively.
- To make sure patients received the best possible coordinated care and treatment staff held a variety of multi-disciplinary meetings to discuss and review patients' needs.
- Staff felt supported and supervised. However information demonstrated poor compliance with annual appraisal by teams and only 69% of staff had clinical supervision from 1 September to 31 December 2014 at the Junction.
- Patients detained under the Mental Health Act 1983 had been informed of their rights and had access to an advocate. However, at the Junction staff had a lack of knowledge regarding agreed and allowed medication under the MHA.

## Our findings

### Assessment of needs and planning of care

We looked at 11 care records. Staff completed comprehensive and timely assessments after admission. Following the assessment patients had on going discussion and personalised assessments relating to the patient's individual needs in line with national guidance. All care records contained up to date, personalised, holistic, and

recovery-oriented care plans. Patients told us that they were aware of and involved in their care planning. Staff had recorded any decisions where patients did not consent to or agree with their care and or treatment.

All of the care records reviewed demonstrated that patients had a full physical health examination in place on admission and had evidence of on going monitoring of physical health care. In addition, all qualified nurses at the Junction had completed physical health assessment management and escalation training. However, at the Junction we found staff had not followed the national recommendations for one patient who required monitoring of their physical signs immediately following their treatment. We reported this to the ward manager and they agreed to make sure this was responded to and action taken.

Staff used routine outcome measures on admission, after six weeks and on discharges with the patients their parents/carers to measure the patients' progress. The outcome measures used were the patient's strengths and difficulties questionnaire, Health of the Nation Outcome Scales, Child and Adolescent Mental Health, Children's Global Assessment Scale, and satisfaction surveys.

The managers had carried out an audit of the care records, to ensure the quality of the care provided.

All information needed to deliver care was stored securely and available to staff when they needed it.

### Best practice in treatment and care

The GP responded to any continuing physical health needs of patients.

At the handovers, we observed that staff followed best practice in treatment and care. We observed a discussion at handover of a post admission assessment for one patient. This consisted of Childs Global Assessment Scale, Health of the nation Outcome Scale, and a strengths and difficulties questionnaire. In addition, we also observed evidence of knowledge of national guidance relating to eating disorders with the use of the Royal College of Psychiatrists Management of Really Sick Patients under 18 with Anorexia Nervosa. These outcome measures help to establish the progress and improvement of the patient. Although the ward did not use the outcome measures to assess the effectiveness of the ward, the trust had plans to improve data collection relating to outcome measures to improve this.

# Are services effective?

Good 

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

Patients had access to therapeutic interventions such as cognitive behaviour therapy, a reflect group, family therapy and a solution focused recovery group.

The Platform had just launched formulation meetings, where all the staff involved in a patient's care focused on their care and treatment and developed a plan of future care.

The Junction participated in the Royal College of Psychiatrists' Quality Network for Inpatients (QNIC). The Platform has not sought accreditation by QNIC. The network aims to demonstrate and improve the quality of inpatient child and adolescent psychiatric in-patient care through a system of review against the QNIC service standards. This process follows a clinical audit cycle with self-review and peer-review.

The wards reported regularly to NHS England commissioners who monitored their overall performance.

The clinical staff had participated in clinical audits, to look at whether the services had complied with the National Institute for Health and Care excellence guidelines for depression and attention deficit hyperactivity disorder ADHD.

## Skilled staff to deliver care

Staff had the qualifications and skills they needed to carry out their roles effectively. There was good uptake of mandatory training, with a overall uptake of over 95%. Staff we spoke with were positive, motivated and passionate to provide good quality care.

The team included a range of mental health disciplines required to care for the patients. This included, consultant psychiatrists, psychologist, social workers, teachers, nurses, support workers and an occupational therapist

We saw nursing staff had completed role specific training such as management training and relational security training.

Staff reported having received management and clinical supervision suitable to their work. However, between 1 September and 31 December 2014 data showed that 69% of staff at the Junction and 91% of staff at the Platform had complied with the supervision requirements. In CAMHS clinical and management, supervision is often the only way of checking the quality of clinicians' work.

The trust provided information to demonstrate that all of the consultant psychiatrists had completed revalidation to ensure they were skilled at their roles.

Although staff said, that they felt fully supported, figures provided by the trust identified gaps in staff having received an annual appraisal. As of the 15 May 2015, the Junction had only completed 18% and the Platform had completed 60% of staff appraisals. The overall compliance for the children's and families network was 25%. Annual appraisal enabled the managers to review staff competency and ensure their development.

## Multi-disciplinary (MDT) and inter-agency team work

We observed two handovers and a multi-disciplinary team meeting where staff displayed knowledge about their work.

A multi-disciplinary team (MDT) is a group of health care and social care professionals who provide different services for patients in a coordinated way. Members of the team may vary and will depend on the patients' needs and the condition or disorder being treated.

The Platform and Junction followed a multi-disciplinary collaborative approach to care and treatment. Nursing staff, occupational therapists, dieticians, teachers, a consultant psychiatrist, specialist doctor, social workers, and a psychologist attended the fortnightly team meetings.

Staff held multi-disciplinary meetings or formulation meetings weekly. Patients had the opportunity to attend the meetings or provide their views before the meeting and have feedback after with their named nurse and the advocate.

Staff at the Platform described good working relationships with the adult crisis teams and the tier four, outreach team.

We observed handovers at both wards, a MDT meeting and a formulation meeting and found them to be thorough and effective. Within the handover staff reviewed patients' potential risks in order to identify changes and agree management plans.

Both wards held care programme approach meetings (CPA) that involved various professionals and families/carers. Additionally, staff gave patients and their families copies of their CPA plans. Patients said they felt able to contribute to MDT meetings and CPA meetings, they said the meetings

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Good 

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were informal and they had support from the advocate at the meeting to present day-to-day issues. A CPA is a way that all inpatient and community services plan coordinate and review at least six monthly an individuals care.

Both teams reported close interagency working with the safeguarding team and community teams when planning admissions and discharge.

## **Adherence to the Mental Health Act (MHA) and the Mental Health Act Code of Practice**

At the time of the inspection, two young people were detained under the MHA at the Junction and one at the Platform.

Staff informed patients about their rights under the MHA. Information was available to young people in a friendly format in the welcome pack. This included their right to have their detention explained regularly (Section 132 of the MHA code of practice) and about the independent mental health advocacy service (IMHA). Patients described contact with the IMHA as helpful during MDT meetings.

We reviewed the MHA documentation at the Platform for one patient, and found it all in order. The patients confirmed they knew their rights under the MHA and said staff revisited this every month. In addition, they had also utilised their right of appeal against their detention.

However we looked at one patient's MHA documentation at the Junction and found that the records were difficult to find and not always accurate. For example, the transfer MHA paperwork for was not readily available on the ward. Also, in the notes reviewed there was confusion regarding which section 17 leave form was the most up to date and in use. This prescribes how often leave has been agreed for the patient and a review of any potential risks for that individual

All staff had completed the mandatory online training on the MHA and their knowledge of the MHA was reasonable, although staff we spoke to were unclear of the difference between T2 and T3 medication processes. These forms state that the patient has either understood the nature, purpose and likely effects of treatment and has consented to or an independent second opinion doctor has agreed the medication is in the patients best interests.

## **Good practice in applying the Mental Capacity Act**

The Mental Capacity Act does not apply to people aged under 16. For children under the age of 16, the young persons' decision making ability is governed by Gillick competence. The concept of Gillick competence recognises that some children may have a sufficient level of maturity to make some decisions themselves. Consequently, when working with children, staff should be assessing whether or not a child has a sufficient level of understanding to make decisions. The Mental Capacity Act does apply to young people aged 16 and 17.

Staff were informed about the MCA. Information from the trust showed all of the staff at the Platform and 78% at the Junction had completed training about MCA.

The information pack given to patients, included information about consent, and the advocacy services. Patients we talked with described providing consent to their care and treatment. For example when and how often they could have leave, they said they felt "listened to" and "free to negotiate" a plan.

Staff regularly discussed patients' capacity during the patients' reviews.

# Are services caring?

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

## Summary of findings

We rated caring as good because:-

- Motivated staff supported patients with care, dignity and respect.
- Patients felt supported and described positive relationships with the staff.
- Patients and their families were involved in decisions and had access to good information in order to make these decisions.
- Patients had the opportunity to provide feedback about the service and staff listened to the feedback.
- Staff had good relationships with patients' families. For example, two parents who work in partnership with staff at the Junction and the Platform had received the National NHS England Participation award

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## Our findings

### Kindness, dignity, respect and support

We observed that staff responded with kindness, dignity, and respect to the individual needs of patients. We saw good Interactions between staff and patients. Both wards had a relaxed and pleasant feel. During handover, we saw that the staff fully understood the needs of the patients.

The majority of patients we spoke with at the Junction said they felt safe and that admission had helped them. All the patients at the Platform were complimentary about staff.

Patients told us “the ward is good”, “plenty to do here”, and “they are always nice”. The patients felt the wards were relaxed. All patients welcomed opportunities available to get off the ward and they said staff supported them to do this.

Responses from 13 patients, friends, and family to a questionnaire about their experience of the wards demonstrated staff had treated patients with courtesy and respect.

Visitors were welcomed and encouraged on the wards.

### The involvement of people in the care that they receive

We found that most patients and their families were involved in their care.

Staff fully informed patients and families about the wards and their care and treatment. The comprehensive admissions pack was available to all planned patients on admission and described as helpful by the patients. The ward had information displayed on notice boards relating to bullying, teenage issues, and ward activities. In addition, patients also told us they were oriented to the ward on admission.

We saw in documentation evidence of active involvement and participation in care planning and risk assessment. Patients were encouraged to attend the participation group and had full access to advocacy services.

The friends and family feedback collected between 1 January and 19 May 2015 for the Junction and the Platform recorded that three patients had responded from the Platform and ten from the Junction. Most feedback forms stated they would be likely to recommend the service, all stated that staff involved them in the planning and delivery of their care and treatment, and that staff were available when they needed them.

Staff had involved patients in the day-to-day running of the ward. Patients had been involved in setting out ward-based rules. There was a suggestion box, which content staff used in the weekly community meetings. These meetings were supported by the social worker and minutes placed on the noticeboard. Patients felt involved in decisions about the ward.

To assure that the trust met its duty to engage with patients, carers and public the trust had a patient experience and oversight group. The minutes of the

## Are services caring?

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meeting 21 January 2015, showed that the group had oversight of the engagement with Healthwatch, implementation of the friends and families test and complaints. This helped to ensure the trust board considered peoples experiences when planning services.

Two parents who worked in partnership with staff at the Junction and the Platform had received the National NHS England Participation award. This category recognised people who show extraordinary commitment to

participating in service development in the NHS. The Crew is a Lancashire-wide group for young people, parents, and carers (whose family use the service) who have previously used the acute inpatient mental health service (CAMHS tier 4).

The Crew works in close partnership with management and commissioners in respect of service development and improvements.

# Are services responsive to people's needs?

Good 

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

## Summary of findings

We rated responsive as good because:-

- Staff planned for patients' discharge from admission and patients' discharge was rarely delayed. The staff used a systematic approach to discharge, employing routine outcome measures to measure the patients' progress and timing of their discharge.
- Patients had the opportunity to take part in activities and education.
- Patients knew how to raise a complaint or raise a concern. Staff had investigated and responded to concerns and complaints in a timely way. Improvements were made to the quality of care because of a complaint.
- Information about the service was available and displayed on ward noticeboards.
- Patients had access to interpreters. Information about how to complain was in available for patients whose first language was not English.
- Staff assessed the number of child and adult beds available in the trust, and responded to this by increasing beds and at times placing patients in adult wards to ensure they received the care and treatment they needed promptly.
- Patients had access to wards that offered comfort and dignity.

by the trust showed children and young people did not always have access to the wards when they were full. This meant the trust used other hospitals out of the geographical area or adult wards.

Children and young people accessed the Junction when they could no longer be safely and effectively managed in their own homes and needed a specialist inpatient service. Staff planned and agreed with the patient prior to admission the necessity for them to be treated in hospital. Staff could accept patients who needed urgent admissions from 9am to 5pm Monday to Friday. The trust had increased the number of beds from eight to ten in response to demand in July 2014.

However, the recent occupancy figures for the six months prior to April 2015 continued to be 98% and staff had placed seven patients in another hospital out of the geographical area because there had been no beds available. The Junction had admitted 20 patients and discharged 19 one patient had a delayed discharge.

Platform admitted young people aged 16 -17 who experienced acute mental health symptoms. The service offered 24/7 access following assessment by the crisis resolution and home treatment team. The bed occupancy for the six months prior to April 2015 was 95%. The staff had admitted and discharged 29 patients. No patients had a delayed discharge. From November 2014 to 1st April 2015, five young people aged 16 and 17 had accessed beds on adult inpatient wards. In addition, three young people had accessed out of the area beds due to lack of bed availability at the Platform.

Staff planned for patients' discharge from admission and patients discharge was rarely delayed. To enable patients' to work towards discharge, staff at the Platform described working towards discharge using a systematic approach, where leave was steadily increased. The wards used routine outcome measures to ensure that they had a standardised way to measure the experience, monitor progression and to plan for the future of patients and their families.

The outreach team also played an active role and participated in the discharge process for young people from the wards. They offered additional outreach work on discharge for a time- limited period.

The average length of stay on both wards reflected this approach. It was 62 days, which is below the national average of 83 days.

## Our findings

### Access and discharge

The child and adolescent mental health community outreach team attached to the wards, co-ordinated the consultation and joint assessment with the community services of all patients referred to the wards for admission. Following assessment, they would work closely with the commissioners, the young person, and their families to locate an available bed. If necessary, they would arrange for an admission out of the geographical area or to an adult ward.

NHS England coordinated and commissioned the inpatient tier four services from the trust. However, the data provided



# Are services responsive to people's needs?

Good 

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

## **The facilities promote recovery, comfort, dignity and confidentiality**

At the Junction, all rooms were en suite. Bedrooms could be personalised by patients. There were sufficient rooms to enable patients to engage in education and activities. A lift was available to access each floor. The outdoor space at the Junction consisted of a garden, football pitch, and a garage containing bicycles, table tennis and other outdoor games available for use.

The ward had a full time teacher and three teaching assistants, and a part time occupational therapist. Lessons occurred for four hours daily. At the time of the visit, there was a variety of activities in progress including a one to one therapy and computer sessions. However, four patients told us that activities did not always take place as planned. Patients had use of telephones and access to the internet dependent upon their individual risks.

At the Platform, the patient bedrooms were en suite. Patients had keys to their bedrooms and bedrooms could be personalised. There were sufficient rooms to enable patients to engage in education and activities. The ward had a small outdoor courtyard.

Education was available for eight hours a week. The ward did not have an occupational therapist but support staff engaged patients in various activities. Patients had use of telephones and access to the internet in the pool room dependent upon their individual risks. Due to the environmental risks, patients had to ask to access these areas to make drinks or snacks.

## **Meeting the needs of all people who use the service**

Both wards had noticeboards with a range of information for patients and their families. Information was available about how to make a complaint.

The wards had disability access; the Junction had a lift to enable patients with a disability to access all three floors. Interpretation services were available.

Staff catered for young people with specific dietary needs. Patients and staff chose and prepared meals together,

Staff enabled patients to access local spiritual services. The Platform used the multi faith room at Preston Royal Hospital.

## **Listening to and learning from concerns and complaints**

We concluded that staff listened to the concerns and complaints of young people and their families. The trust had a complaints procedure that was summarised in leaflets and on their website. The information was available in easy read format and other languages, such as Urdu, Polish and Gujarati. Both services had a suggestion/complaints box in reception. Patients told us they knew how to make a complaint.

Staff responded to complaints with the assistance of the customer care department, whose role was to process and manage complaints, concerns, and compliments. The customer care team worked with the investigation leads to improve quality and do review investigations on request. Team and clinical managers carried out the investigations into the complaints.

When young people and families had raised concerns, we found the managers had responded and changes made to the service. For example, when staff had given one patient the wrong information on discharge, the staff had recognised the need to improve internal communication. From the data provided by the trust there had been seven complaints in the previous 12 months of which the trust upheld six (86%). No complaints about the wards were referred to the Parliamentary and Health Service Ombudsman. The patients we spoke with said they had received feedback from their complaints

Staff also commented they received feedback on the outcome of complaints investigations and then acted on the findings.

# Are services well-led?

Good 

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

## Summary of findings

We rated well-led as good because:

- Managers had systems in place to monitor the performance of the wards and to review any risks to the patients' experience.
- Staff described good teamwork, displayed compassion, respected and showed dignity to patients and this reflected the trusts vision and values.
- Staff described a clear management structure and visible managers. Staff knew the senior managers in the trust.
- Staff felt supported and morale was good and said they felt confident to raise any concerns.
- To improve wards, the children's and families network service had a specific operational plan for 2015 to 2016 for CAMHS. This included a review of the weakness, strengths, opportunities, and threats of the CAMHS tier three and four services.
- Staff had shown innovation and good practice when encouraging families to participate in the service. They had participated in QNIC to drive improvements in the service.

However, we found areas where the trust must or should improve. Where:

- Staff had not adhered to the MHA Code of Practice in respect of seclusion.
- The ward action plan resulting from health, safety and environmental audit was unclear regarding the fixed ligature points on the ceiling at the Platform.

## Our findings

### Vision and values

The ward manager explained that the trust based the annual personal development review on the trust values. Staff said two members of the trust board had worked on a shift recently and attended a MDT. Staff described a clear management structure and visible managers. Staff knew the senior managers in the trust.

Staff we spoke with were motivated and dedicated to give the best care and treatment they could to young people and children. Staff described good teamwork, displayed compassion, respected and showed dignity to patients. This reflected the trusts' vision and values.

### Good governance

The governance systems informed senior managers of any issues or risk of poor performance. Ward managers reported to the tier four governance meeting. This fed into the overall CAMHS governance meeting, and this reported to the child and families' network board, chaired by the director. The meetings reviewed the teams' monthly performance and risk registers.

The trust provided a performance monitoring report for March 2015, which showed the trust had developed actions to some of the issues identified. Staff had the ability to submit items to the risk register.

Compliance with mandatory training was good and staff had the opportunity to take up other training specific to their roles however we witnessed a gap in knowledge of one member of staff in the use of the rescue equipment at the Platform.

Staff talked confidently about their roles and understood the management structure. They saw the ward managers as supportive, transparent, and felt enabled staff to raise concerns. All staff reported that they liked working on the wards. Staffing establishments were reviewed by the ward managers and increased should the need arise.

Staff said the ward managers supported and supervised them in their roles. Staff reported incidents and mostly learnt from investigations. Staff prioritised safeguarding children and young people. Staff had provided the opportunity for patients and their families to participate with the service. Patients reported a good experience whilst on the wards.

However, we identified areas where the trust must or should make improvements. Such as staff had not adhered to the MHA Code of Practice in respect of seclusion. The amount of staff who had completed their annual appraisal was low. The ward action plan regarding the management of environmental risks was unclear.

### Leadership, morale and staff engagement

Staff we spoke with said they worked well as a team and felt supported by their direct line managers. They said they



# Are services well-led?

Good 

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

felt involved in the design of the services and they worked in motivated and proactive teams. Staff were aware of what they were responsible for and the limits of their authority. They talked positively about morale and teamwork on the wards. Some staff said they felt proud and wanted to work on the wards.

All the staff felt able to raise concerns without fear of victimisation. The trust had introduced 'Dear Derek' an online form on the trust's internet to enable any member of staff to raise a concern quickly, effectively and in confidence to the trust's chairman about any wrongdoing or poor practice when they saw it.

Managers had the opportunity for leadership training, this included performance, sickness, quality improvement and managing capability.

Staff said they had the opportunity to give feedback on the wards and input into any future developments. They reported this happened at ward meetings and trust engagement meetings. Some told us that the managers encouraged innovation. We saw copies of staff meetings minutes at the Junction which demonstrated this.

## **Commitment to quality improvement and innovation**

The trust had systems in place to monitor the quality of the services. For example, the children and families' network

service had a specific operational plan for 2015 to 2016 for CAMHS. This included a review of the weakness, strengths, opportunities, and threats of the CAMHS tier three and four services.

There was evidence of the trust managing the performance and quality of the service. Such as the monthly performance report that included the information about bed occupancy and discharge. In addition, the trust had recently introduced the quality, safety, experience, effectiveness, and leadership to monitor the trusts' compliance with the Health and Social Care Act 2010.

Staff had participated in clinical audits to drive improvements, such as self-harm.

The wards reported regularly to NHS England commissioners who monitored their overall performance.

The Junction and Platform participated in the Royal College of Psychiatrists' Quality Network for Inpatients, which is a peer review system.

Staff had shown innovation and good practice when encouraging families to participate in the service.

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

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

#### Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

**We found that staff had not adhered to the MHA code of practice or followed their own policy regarding seclusion at the Platform. Staff described secluding patients in the extra care area but we found they had not followed the MHA code of practice in regards of seclusion.**

One seclusion record out of the five reviewed had no evidence of who started and who ended seclusion. Three records did not have 15-minute recordings of the progress of the patient. Medical reviews were evident in some records but it was difficult to ascertain who was independent and when the medical review took place.

This is a breach of regulation 13( 7) (b)

The trust must make sure staff adheres to the Mental Health Act code of practice when secluding patients at the Platform.