Livewell Southwest

Plym Bridge House Specialist TIER 4 NHS Service for Young People with Mental Health Problems
Operational Policy

Version 3.4
Review: November 2017

Please note that this policy will be reviewed in line with SystmOne - the new computerised system which will replace e-PEX.

Notice to staff using a paper copy of this guidance

The policies and procedures page of LSW Intranet holds the most recent version of this document and staff must ensure that they are using the most recent guidance.

Author: **Unit Manager/ Modern Matron TIER 4 CAMHS**

Asset Number: **795**

Reader Information

Title	Plym Bridge House Specialist TIER 4 NHS Service for Young People with Mental Health Problems. Operational Policy. v.3.4
Information Asset Register Number	795
Rights of Access	Public
Type of Formal Paper	Policy
Category	Clinical
Format	Word Document
Language	English
Subject	Tier 4 NHS inpatient service for adolescents with mental health problems throughout the South West Peninsula as a single service delivered through agreed providers**.**
Document Purpose and Description	Operational policy describing the function of the Peninsula CAMHS Tier 4 Inpatient Unit.
Author	Unit Manager/Modern Matron Tier 4 CAMHS
Ratification Date and Group	19th March 2014. Policy Ratification Group
Publication Date	7th April 2017
Review Date and Frequency of Review	Three years after publication, or earlier if there is a change in evidence.
Disposal Date	The Policy Ratification Group will retain an e-signed copy for the archive in accordance with the Retention and Disposal Schedule, all copies must be destroyed when replaced by a new version or withdrawn from circulation.
Job Title of Person Responsible for Review	Unit Manager/Modern Matron Tier 4 CAMHS
Target Audience	All LSW staff and any healthcare professionals from other trusts or organisations that access the Peninsula CAMHS Tier 4 Inpatient Unit.
Circulation List	Electronic: Plymouth Intranet and LSW website Written: Upon request to the Policy Ratification Secretary on ☏ 01752 435104. Please note if this document is needed in other formats or languages please ask the document author to arrange this.
Consultation Process	Assistant Director of Comprehensive CAHMS. Children's Health Commissioners, Cornwall, Devon Plymouth & Torbay. Plym Bridge House Staff. Care Quality Commission (as part of registration)
Equality Analysis Checklist completed	Yes
References/Source	Health Advisory Service 'Together We Stand', A thematic review of Child and Adolescent Mental Health Services. (1995) The review proposed a four Tier model for commissioning and delivering comprehensive services. Quality Networks in In-Patient Child & Adolescent Mental Health

	Services, The Royal College of Psychiatrists Centre for Quality Improvements.(QNIC) (2009) QNIC Service Standards Fifth Edition. Child & Adolescent Mental Health Nursing (2006) Tim McDougall Blackwell Publishing. Department of Health and Department of Education and Skills (2004). National Service Framework for Children, Young People and Maternity Services. Standard 9: the mental health and psychological well-being of children and young people. Department of Health (2008) Code of Practice, Mental Health Act 1983 Published Pursuant to Section 118 of the Act. Chapter 36.43 Children & Young People under the age of 18. National Mental Health Development Unit (2009) Working Together to Provide Age Appropriate Environments & Services for Mental Health Patients Under 18. National Mental Health Development Unit (2009) The Legal Aspects of the Care & Treatment of Young People with Mental Disorders. Department of Health (2009) New Horizons Towards a Shared Vision for Mental Health (Consultation). Department for Children, Schools and Families (2010) Working Together to Safeguard Children. HM Government The Children Act 1989 HM Government The Children Act 2004
Associated Documentation	Impact Assessment tool. Children Act 1989
Supersedes Document	Specialist Tier 4 NHS Service for young people with mental health problems, operational policy V3
Author Contact Details	By post: Local Care Centre Mount Gould Hospital 200 Mount Gould Road Plymouth Devon PL4 7PY Tel: 0845 155 8085 Fax: 01752 272522 (LCC Reception)

Document Review History

Version No.	Type of Change	Date	Originator of Change	Description of Change
For previous review history please contact the PRG secretary.				
1.2	Move to New Build	25.7.11	Modern Matron Tier 4 CAMHS Service	Final Amendments
V2	Reviewed	Dec 2011	Author	Ratified.
V3	2 Protocols/Policies added as part of LSW review of policies. Section 85 LSW Policy and Seclusion Policy for Plym Bridge House which replaces ECA policy. Removal of the Activity risk assessment form. Addition of Smoking guidelines. Addition of Young people's information re. Supportive observations.	July 13	Modern Matron Tier 4 CAMHS Service	Sent for ratification
V3.1	Reviewed	January 2014	Modern Matron Tier 4 CAMHS Service	Minor amendments
V3.2	Updated	June 2015	Modern Matron - Plymouth Community and Inpatient CAMHS	Appendix P. Sentence added to clarify that a young person with be held on a 5(2) of the MHA once they go into seclusion and will be formally assessed.
V3.3	Extended	May 2016	Information Governance, Records, Policies & Data Protection Lead.	Formatted to LSW and Extended
V3.4	Extended	April 2017	Unit Manager	Extended

Plym Bridge House Specialist TIER 4 NHS Service for Young People with Mental Health Problems. Operational Policy.		Page No.
1	Introduction	7
2	CAMHS Overview	7
3	Service Provider	8
4	The Peninsula CAMHS Tier 4 Unit	9
5	Admission Criteria	12
6	Outline of Service	13
7	Service Delivery	15
8	Outreach	16
9	Consultation and Teaching	16
10	Review of Cases	16
11	Discharge	17
12	Violence and Aggression	18
13	Safeguarding	18
14	Use of the Meeting Room	18
15	Smoking	18
16	Staffing Profile	18
17	Operational Management	19
18	Day Time Access to Bedrooms	21
19	Emergency Contingencies	22
20	Transfer of Young People to more intensive services	22
21	Information Strategy	23
22	Representations and Complaints	23
23	Infection Control	24

24	Training	26
Appendix A	Therapy Groups	28
Appendix B	Therapeutic Group Programme	31
Appendix C	Protocol for all therapeutic Group Outings	37
Appendix D	Body searches	38
Appendix E	Food Hygiene Policy	39
Appendix F	Television and Video/DVD Use	50
Appendix G	Ground Rules	51
Appendix H	Plym Bridge House Unit Smoking Guidelines	53
Appendix I	Plym Bridge House Garden Guidelines	55
Appendix J	Anti Bullying Protocol	56
Appendix K	Outline of a Day at Plym Bridge House	60
Appendix L	Young persons guide to Supportive Observations	63
Appendix M	Young persons guide to Seclusion	68
Appendix N	Physical Intervention Protocol	70
Appendix O	Section 85 Children Act Notification Policy	72
Appendix P	Seclusion Policy	78

Plym Bridge House Specialist TIER 4 NHS Service for Young People with Mental Health Problems

1. Introduction

1.1 This document provides the operational policy for the Tier 4 NHS inpatient service for children and young people with mental health problems throughout the South West Peninsula as a single service delivered through agreed providers. Trusts will work collaboratively to common protocols and guidelines and provide an integrated model of care across inpatient and other settings.

1.2 The Plym Bridge House is a Tier 4 tertiary twelve bedded general adolescent psychiatric unit with two extra Care area beds serving the population of 12 to 18 year olds in Devon & Cornwall with severe mental health problems/mental illness requiring inpatient admission. Young people are admitted for acute, short-term assessment and treatment, these are young people who present with mental health problems/mental illnesses of such a high intensity &/or risk that their needs cannot be met within the community. Young people can be admitted informally, by parental consent or detained under the Mental Health Act. The overarching principle of the unit is to provide highest standards of care and treatment for young people in the least restrictive way for the minimum amount of time.

The address of the unit:
Plym Bridge House
4 William Prance Road
Crownhill
Plymouth
PL6 5ZD

The unit serves the population of four health areas (Cornwall, Plymouth, Devon and Torbay). The service opened on 27 January 2007 in a transitional building at Cotehele on the Mount Gould Hospital site

1.3 Aim of the Service

- To provide acute, short-term assessment and treatment to young people who present with any mental health disorder of such as high intensity and risk that their needs cannot be met within the community.
- The overarching principle of the unit will be to provide care and treatment in the least restrictive way for the minimum amount of time.

2. CAMHS Overview

2.1 Child and adolescent mental health services (CAMHS) promote the mental health and psychological wellbeing of children and young people, and provide high quality, multidisciplinary mental health services to all children

and young people with mental health problems and disorders to ensure effective assessment, treatment and support, for them and their families.

2.2 The term CAMHS is commonly used as a broad concept that embraces all those services that contributes to the mental health care of children and young people (Comprehensive CAMHS).

2.3 CAMHS delivers services in line with a four-tier strategic framework described in the Health Advisory Service Document Together We Stand (1995), this outlines a four tiered model for providing CAMHS from Tier 1 (generic and comprehensive services for children and young people, i.e. GPs, schools, Social Services and the voluntary sector) to the most specialist services Tier 4, i.e. children and young peoples inpatient units. This is now widely accepted as the basis for planning, commissioning and delivering services.

2.4 The relative efficiency, of Tier 2 and 3 CAMHS services means that the number of young people presenting in need of Tier 4 intervention is variable, although their number is small.

As Tier 2 and 3 CAMHS services continue to refine their service provision, the nature and case complexity of those individuals and families requiring Tier 4 interventions will change. The specialist Tier 4 Unit will continue to refine its services to meet the perceived need at Tier 4.

Close links will be developed between the Tier 4 Unit and local CAMHS at Tiers 2 and 3 to guide the continued development of this new service.

2.5 The development of the Tier 4 service has been on a Peninsula wide basis. It is recognised that no one unit will be able to meet all the mental health needs of all children and young people at any given time.

Tier 4 units, providing an extremely specialised service to meet very individualised needs, have developed on a national basis both in the NHS and the independent sector. The specialist Tier 4 Unit aims to forge links with other Tier 4 providers, particularly Broadway Park (Somerset), both locally and nationally, and to access their expertise as needed.

3. Service Provider

3.1 Livewell Southwest (LSW) is the approved provider of Tier 4 CAMHS services across the South West Peninsula. The LSW is a provider of children's services to Plymouth and North & East Cornwall.

3.2 The Unit offers a highly specialised tertiary level service to young people with the most serious mental health problems. It is an inpatient unit as defined by the Health Advisory Service (HAS) document " Together We Stand" and Standard Nine of the National Service Framework (NSF) for Children, Young People and Maternity Services.

3.3 Tier 4 services provide a specialist clinical service in order to enable local Tier 2 and 3 CAMHS to meet the needs of children and young people with complex difficulties. The provision is based on an inpatient facility and the services usually provide an assessment and a range of specialist treatment packages and interventions, as well as a consultation service to professionals. The four tiers of CAMHS operating together within a single pathway is described as Comprehensive CAMHS.

3.4 CAMHS for children, young people, and their families at Tiers 2 and 3 are provided within the geographical and commissioned boundaries of the LSW.

Plymouth CAMHS is sub-divided into teams and departments to facilitate the provision of quality, individualised packages of care to service users and their families.

3.5 The specialist CAMHS Tier 4 Unit is home to one of these teams. It provides Tier 4 inpatient services for children and young people across Devon and Cornwall. The service is predominately short stay inpatient care for 12-18 year olds with acute mental health difficulties.

3.6 There will be the provision for accepting Extra Contractual Referrals (ECRs) of young people from outside of the Peninsula but it is anticipated that the majority of children and young people will be from the Peninsula geographical area.

4. The Peninsula CAMHS Tier 4 Unit

4.1 The team working within the Unit will also provide a consultation service for other professionals.

4.2 The specialist CAMHS Tier 4 Unit is a part of Livewell Southwest’s North West Locality. The Unit operates within the guidelines, policies and procedures produced by this LSW. All operational support will be LSW approved.

4.3 Statement of Philosophy

4.3.1 The key principles and values that underpin this service are that:

1. Children and young people under 18 are treated in an environment suitable to their age.

2. The needs of a young person may be different from those of their family/carers. Community services need to take a holistic approach to the needs of both; the inpatient unit is specifically for young people and their needs should be given priority.

3. Young people should be cared for in the most homely and non-institutional setting that can meet their needs.

4. Placing young people long distances away from home can be detrimental to their future reintegration into their local community and should be avoided whenever possible and/or appropriate, and where unavailable be as short as possible and every effort made to maintain local links.

5. Services are expected to involve parents in treatment and care, including the provision of accommodation where appropriate. Providers are expected to actively facilitate opportunities for children and young people to regularly communicate with their friends.

6. Young people have the right to feel safe. They need the opportunity to describe what this means in terms of service design and delivery.

7. Young people have the right to an education and to have fun: this needs to be integral to the design of the service.

8. Young people should be cared for in the least restrictive environment possible. Secure accommodation should not be sought unless they present a serious risk to themselves or others, or their behaviour is criminal rather than anti-social.

9. The need for security and safety should be handled positively so that young people do not see it as punitive.

10. Meeting the individual needs of each young person is the basis upon which provision of services and assessment is carried out. There should be a comprehensive range of services offered, including inpatient services.

11. The emphasis should be upon working with families and young people at an early stage to prevent problems escalating in either the short or long term.

12. Young people should be supported in the community wherever possible.

13. Young people need an ongoing input in the design and delivery of services to meet their needs.

14. Interventions should be based on evidence of effectiveness or, where evidence is lacking, on expert clinical consensus.

4.3.2 The specialist CAMHS Tier 4 Unit aims to provide a non-stigmatised, non-institutional caring environment in which young people are encouraged to make decisions about their lives. When ever possible parents/carers will play a major role in decision-making.

4.3.3 Staff aim to provide a positive role model for the young people to promote feelings of safety and to foster appropriate adult – young person relationships.

4.3.4 Attempts are made to establish individual therapeutic programmes informed by the best available evidence of effectiveness. It is likely that treatment will include a broad range of intervention styles. Young persons are encouraged to make choices about their therapeutic programmes, diet, life skills and interpersonal relationships whenever practical and clinically appropriate.

4.3.5 The focus of the Unit will be to reduce the difficulties the young person is experiencing and therefore to facilitate an expedient return to the community.

4.3.6 The Unit aims to develop skills to better equip the young person to meet the challenges that lie ahead. This focus is not to negate the factors and events that have shaped the young person, but to concentrate on how the young person will change those attributes, characteristics and behaviours that are negatively impinging on their lives. This will involve the young person having to re-examine and overhaul attitudes and coping mechanisms as well as learning new skills and techniques.

4.4 The aim of the Unit is to provide a short stay environment i.e. 3 months for young people with acute mental health difficulties.

The objectives are:

1. To provide assessment and treatment for young people with severe mental health difficulties. Choice of treatment will be based on the use of evidence-based practice.

2. To reduce the severity of the difficulties experienced by the young person and their parents/carers to a level that will be able to be managed by the community services in their local area.

3. To educate the young person regarding symptom recognition and early intervention/management strategies to reduce the probability and severity of any possible relapse.

4. To help the parents/carers better understand the nature of the difficulties and how to minimise their impact on the young person – psychologically, educationally and socially – as well as to reduce the effects within the home environment.

5. To help facilitate the reintegration of the young person to social, educational and/or employment aspects of functioning as developmentally appropriate.

6. To help the young person begin to form or re-establish appropriate relationships with parents/carers, other family members and peers.

7. To create an environment that is culturally aware, and operates in a non-discriminatory way. To provide fair access to individualised care packages for service-users with disabilities, where admission to the Unit is seen as beneficial to the individual.

8. To treat young people with respect and dignity.

5. Admission Criteria

Admissions for assessment will not last longer than eight weeks.

5.1 Services, including in-patient care, are offered where the following criteria are met:

- Intervention is likely to make a positive contribution to the welfare of the young person.

- Clarity about the responsibility for the young person's assessment and treatment has been agreed in partnership with parents/carers, where appropriate.

- The young person, as the identified patient, has a serious mental illness or psychiatric disorder likely to respond to specific treatment, and to benefit from a hospital admission.

- Alternative, locally based services are not appropriate or available.

5.2 Clarity about the young person's home base in the community prior to admission has to be agreed. There is a requirement for information concerning the young person's educational status.

5.3 Exclusion Criteria

5.3.1 In the event of co-morbidity, careful consideration would have to be given to the amenability of the presenting psychiatric disorder to inpatient treatment. The Unit team will notify the referring local CAMHS, in writing, of the outcome of the assessment and the rationale for the decisions

made.

The Unit will not be able to provide a service for young people who have:

1. Detoxification from addictive substances (current or ongoing).

2. Conduct problems where this is the primary diagnosis.

3. Require a secure provision as detailed by the Children Act for their social care needs to be met.

4. Forensic mental health needs.

5. Young people who have a learning disability and no co-morbid mental illness.

6. Young people who have a Moderate or Severe learning disability.

6. Outline of Service

6.1 The CAMHS Tier 4 Unit offers a seven-day, fifty-two week, inpatient service with access to a maximum of twelve single en-suite bedrooms with the added facility of a two bedded Extra Care Area (ECA). The Unit will provide the opportunity to admit young people at any time of the day or night.

6.2 The age range of service users is after the twelfth and to the young person's eighteenth birthday. The commissioners of the service have approved this age range. However in exceptional circumstances, when it is clinically and developmentally appropriate, admissions outside this age range may be considered.

6.3 Individual treatment plans are based on a developmental approach to the problems of children and young people. This eclectic approach incorporates adolescent mental health issues, family context, and cultural, social, educational and employment factors into the formulations.

6.4 Referrals to the unit are accepted on the basis that there is a bed available. The unit does not operate a waiting list. If there are no beds available the referrer will need to look elsewhere for a service.

6.5 Referrals are made to the Unit through the local CAMHS, which has responsibility for the permanent address of the adolescent, normally by and with the knowledge, of the locally based Consultant Child/Adolescent Psychiatrist.

6.6 The referral should be made in writing to the Unit Consultant Psychiatrists for discussion at the multidisciplinary referrals meeting. Referrals should give comprehensive information about the young person, including

information about the involvement of other agencies.

6.7 Members of the Unit multidisciplinary team will assess the young person at the first available assessment slot and a pre-admission network meeting will be arranged as quickly as possible. Any decisions will be made as soon as is practical and the young person, parents/carers and referrers will be informed as soon as possible of the outcome. This would usually follow the assessment meeting.

6.8 Emergency referrals via the telephone are acceptable and would need to be followed up by fax, then letter. Assessment will take place as soon as possible, usually the same day, to meet any urgent need for admission.

6.9 Where admission is deemed inappropriate, or agreement with the parents/carers cannot be reached, guidance on alternative services provided by the team, or by other agencies, will be offered to the family and/or referrer whenever possible.

6.10 Young people, parents/carers, referrers and other relevant agencies will be expected to participate in the process of assessing the most helpful responses and negotiating the treatment package devised and implemented.

6.11 Assessments for admission will be carried out either in the Unit or in the community; as deemed to be clinically appropriate. However young people should be encouraged to visit so they are able to get an accurate impression of the Unit.

6.12 To give a broader perspective on the presenting issues, two senior members of the multidisciplinary team from differing professions will normally carry out assessments. These meetings will include parent/carers whenever possible.

6.13 It would be preferable to hold a pre-admission meeting with professionals involved in the care of the young person in order to clarify treatment and joint working issues and to begin setting the agenda for discharge. Involvement of all relevant team members from the Unit and staff from external agencies in discharge planning will be expected from the outset, however pre-admission meetings would not be required when an emergency admission was indicated.

6.14 If indicated by the assessment and agreed with referrers, admission will follow as quickly as negotiation with parents/carers and bed occupancy will allow.

6.15 Once a young person has been assessed and it is agreed that the Unit will be involved with the care of that young person, the medical responsibility resides with the Unit Consultant Psychiatrist until the young person is discharged and/or referred on from the service.

7. Service Delivery

7.1 The Unit comprises of 12 single en-suite bedrooms with the added facility of a two bedded Extra Care Area (ECA) and space to accommodate Therapy and treatment, alongside living areas and educational facilities Words Removed All service users are allocated a case manager and key worker who negotiates the individual care plans with the clients and arranges regular reviews of these care plans.

7.2 The individual packages of care will comprise a mixture of psychiatric intervention, medication, group and individual therapeutic interventions that are specifically designed to meet the individual's assessed needs. It is hoped that the structure and routine of the Unit will provide a containing milieu that has a therapeutic benefit for young people.

7.3 There will be an emphasis on symptom recognition and self-management for the young person to reduce the risks of future difficulties. The main overall strategy for this will be a "thinking then acting", problem solving type approach to overcoming the difficulties and challenges the young person faces. The emphasis on each component of this approach will vary depending on the presenting difficulties, the assessed needs, the stage of treatment and the maturity of the individual.

7.4 Early treatment interventions are likely to be more behavioural and medical and in the latter stage more cognitive/dynamic. There will be a flexible response to difficulties to reduce the risks of future complications. There will be a use of creative therapies to help provide focus for the young person and to aid self-expression.

7.5 Education will be provided during the school term and young people will work to a programme designed to suit their own assessed needs and abilities. Education staff will attempt to meet national curriculum core subjects within the limitations of the facilities on the Unit (e.g. no laboratory facilities). Liaison with the young person's school and parents/carers is regarded as an essential part of the continuing educational provision.

7.6 Members of the multidisciplinary team will contribute to Assessments of Special Educational Needs as required and appropriate advice to be given re young peoples mental health problems.

7.7 School leavers will be given guidance about the possibilities open to them in the work place or further education. Guidance concerning securing accommodation, if required, will also be available. There is a programme of life and social skills, which will be tailored to meet the needs of each young person. Establishing links with the relevant Connexions services will be important in supporting young people who have spent time in the Unit.

7.8 Medication will be prescribed where clinically indicated.

7.9 An activities programme will be available to all young persons on the Unit. This will vary according the service user group mix, available resources, the weather and the seasons.

7.10 The unit will be funded by commissioners from across the Peninsula, with bed space purchased on a bed day basis.

7.11 The in-house social worker will liaise with the local area offices of Social Services as part of the overall care package for the young persons. Developing links with relevant departments in social services to discuss benefits or housing will also be important in helping the young people prepare for leaving the Unit.

8. Outreach

8.1 In the negotiations with young people and their family/carers around admission and discharge, it is often helpful to undertake work that is not Unit based. Therefore, it may on occasion be useful to provide a limited number of individual or family sessions. This could be in the family home or at the young persons' local CAMHS clinic, to facilitate admission to the unit and for transition of discharge to the community team where the young person will receive ongoing care.

9. Consultation and Teaching

9.1 Consultation may be offered to the referring agency as an alternative to direct service user treatment. This would be by negotiation and may take the form of a single consultation or an agreed number of sessions.

9.2 Consultations are offered by all professions in the multi-disciplinary team.

9.3 Consultancy services may be offered to individual professionals, teams and organisations.

9.4 The Unit will also provide seminars and teaching in the field of specialist adolescent mental health services.

9.5 The Unit will offer placements to students and trainees of various appropriate disciplines by negotiation.

10. Review of Cases

10.1 All cases are subject to periodic review usually at six weekly intervals. Young people are expected to participate in the review process and their parents/carers will be invited and positively encouraged to participate in this process through regular meetings.

10.2 Summaries and other relevant information will be supplied to referrers at agreed intervals.

10.3 Changes in the circumstances around a case may occasionally result in a decision to re-negotiate or transfer treatment. This could include changes in a young persons' clinical presentation such as violence or aggression that required transfer to a more secure provision.

10.4 Changes in circumstances would be considered on an individual basis to determine the most appropriate course of action. In such circumstances, the available options would be discussed with the parent, care coordinator or referrer before a decision is taken. Issues around sanctions and redress may be found in Livewell Southwests Violence & Aggression Management Policy.

10.5 The negotiation of the treatment packages always takes account of the need to provide a safe environment, the physical limitations of the buildings and the total human and material resources available to the service user group as a whole.

11. Discharge

11.1 The multi-disciplinary team will make the decision to discharge in negotiation with parents/carers, referrers and the young person. This decision will take account of the treatment goals negotiated at referral and any subsequent reviews.

11.2 An agreed after-care package will be negotiated with the young person, parents/carers and referrers. Other relevant agencies, e.g. social services, will also be involved in this process (see 8.4 above).

11.3 The Care Programme Approach will be used, creating a framework for discharge planning and aftercare. It will help to ensure that several principles of good practice are realised, including systematic planning, recording and reviewing the young person's care and support, as well as ensuring a proactive approach is taken to provide a swift and appropriate response if a young person's mental health deteriorates.

11.4 In the event of "discharge against medical advice" the referral agency would be informed as soon as is practically possible.

11.5 Referrers will routinely be sent a discharge package containing a synopsis of the case, interventions undertaken and recommendations for any on going care the young person or their family might require. The multi-disciplinary team will prepare this subsequent to the pre-discharge network meeting.

12. Violence and Aggression

12.1 Any form of violence or aggression is not acceptable in the specialist CAMHS Tier 4 Unit. Sensitivity will be given to each individual case and assaults may result in police involvement and charges being pursued in line with Livewell Southwests Violence & Aggression Management Policy. All staff within the specialist CAMHS Tier 4 Unit will undergo training in conflict resolution and Physical Intervention techniques by approved tutors.

13. Safeguarding

- Child Protection - The Specialist CAMHS Tier 4 Unit will follow Livewell Southwest's policies.

- Safeguarding adults - The Specialist CAMHS Tier 4 Unit will follow Plymouth Community Healthcare's policies.

14. Use of the Meeting Room

14.1 Plym Bridge house contains a large meeting room sited in the staff section of the building, when this is to be used by staff not connected to Plym Bridge House, they will be shown into the waiting area where Reception staff at the unit will welcome them and facilitate their access through the staff entrance at the rear of the building & will then escort visitors to the meeting room. Visitors therefore will not pass through the young people's area of the building.

15. Smoking

15.1 Livewell Southwest has adopted a smoke free policy that applies to young people, staff, visitors and contractors for all LSW buildings & grounds. Staff members will undergo smoking cessation training therefore to assist young people to cease smoking if required, alternatively advice and support will be sought from Livewell Southwest's smoking cessation team. **Please refer to Plym Bridge House Smoking Guidelines page 51 of this document.**

16. Staffing Profile

16.1 The management team of the Unit is comprised of a Unit Manager/Modern Matron, Consultant Adolescent Psychiatrist & Clinical Psychologist. This is to ensure that all disciplines are represented within the senior management structure this team is joined by the Education Manager, Deputy Unit Manager and unit Administrator.

16.2 The staff establishment of the Unit is: -

- 1.5 WTE Consultant Psychiatrist

- 1.0 WTE Unit Manager/Modern Matron
- 1.0 WTE Clinical Psychologist
- 1.0 WTE Deputy Unit Manager
- 0.5 WTE Child Psychotherapist
- 0.5 WTE Art Therapist
- 1.0 WTE Occupational Therapist
- 0.5 WTE Family Therapist
- 0.5 WTE Social Worker
- 0.1 WTE Dietician
- 1.0 WTE Education Manager
- 1.0 WTE Nurse Consultant
- 0.5 WTE Teaching Assistant + sessional teachers
- 2.0 WTE Clinical Team Leaders (Band 6 Nurses)
- 17 WTE Band 5 Nurses
- 13 WTE Band 3 Nurses
- 1.0 WTE Administrator
- 1.0 WTE Medical Secretary
- 2.4 WTE Housekeepers

16.3 The Adolescent Unit Team will be assisted by the normal inpatient support services e.g. Pharmacy, Sterile Supply Services, Hotel Services etc. These services will be supplied by Livewell Southwest in accordance with Service Level Agreements negotiated before the operation of the Unit. These SLAs will be subject to monthly or quarterly performance monitoring (dependent on the contracted service) and overall review on an annual basis.

17. Operational Management

17.1 The Unit will contain a varying mix of informal and detained patients. Thus there will need to be a continuum of rules and boundaries to be able to meet both legal requirements and the therapeutic needs of the young people.

17.2 Young people will be encouraged to take an instrumental role in their treatment. It is, however, recognised that this capability will vary with developmental factors and mental state.

17.3 In the main the Unit will function on the principle of "informed consent". This will take the form of 'therapeutic contracts'. These may be formally written down or may take the form of agreed aims, goals and objectives. The 'therapeutic contracts' will be devised by the multidisciplinary team and will be clearly set out in the nursing care plans.

17.4 There will be an expectation that the young person will adhere to the agreed treatment packages and will endeavour to attain set treatment goals. It is recognised that detained children and young peoples may find this more exacting and the Unit's response in a given situation would

reflect this.

17.5 Referrers, parents/carers and relevant agencies will also be part of the therapeutic contract negotiations and would also be expected to adhere to these as agreed.

17.6 The range of interventions would vary depending on the maturity, abilities and presenting difficulties of the individual. However the range would include: -

- Art therapy (mainly group therapy but individual art therapy available)
- Mindfulness
- Relaxation
- Anxiety management
- Anger management training
- Behavioural programmes
- Problem solving skills training
- Symptom recognition
- Cognitive behavioural therapy
- Eye movement desensitization & reprocessing
- Social skills/life skills training
- Conflict resolution
- Individual counselling
- Creative therapies
- Family therapy
- Physical activity and sports group
- Relapse prevention
- Psycho-education to young people and families
- Education
- Psychotherapy (Both individual and group sessions)

17.7 There will be an expectation that young people will take part in educational activities whilst being cared for in the Unit. This will range from in house education for those of school age through to continued attendance of school or college of origin and participation in life skills training both on and off the Unit.

17.8 There will be an expectation that the young persons will share some of the responsibilities of communal living. This will include some "domestic" chores. This will also comprise part of the life skills package, particularly for the older adolescent preparing for independent living.

17.9 Young People are encouraged to take leave from the unit provided they are risk assessed to be able to safely have leave. Discussions re leave will take place during MDT meeting and between the nursing and medical team. Prior to <u>each</u> period of leave each individual Young Person will be risk assessed. The risk assessment will be a meeting between the Young Person and a member of the nursing team, medical or therapy team

looking into the individual risks of that Young Person - to include their history, current presentation, physical health and risks to themselves/others. This is then logged by the member of staff, electronically via Epex. Leave activities can include: group trips out to educational activities, activities of daily living – buses, shopping etc, leave with family/friends or unescorted leave. If the Young Person is detained under the Mental Health Act the above assessments will be made and the terms of the Section 17 leave must be adhered to.

17.10 The main entrance door is locked for Young People's safety to prevent access from unknown visitors to the unit.

If or when Young People want to leave the unit they need to meet with one of the nurses to discuss their leave. Young People will have individualised care plans specifying their leave entitlements.

18. Day Time Access to Bedrooms

18.1 Young people are admitted to Plym Bridge House for assessment & treatment of their mental health difficulties, in order that this may facilitated and to continue to attempt to meet educational needs of young people, it is vital that young people are supported and enabled to attend the therapeutic programme, individual therapy, therapeutic activities and education.

18.2 In order that the above may occur, during the therapeutic programme times young people will need to remain in the main living areas of the unit to participate in these activities and for that reason the unit will need to limit young people's access to bedrooms, unless young people are physically or mentally to unwell to attend the therapeutic programme

18.3 When young people leave the bedrooms area of the unit in the morning they will be expected to remain in the main living areas for the rest of the programmed day between 0830 & 1600. Young people can at any time request of staff to go to their bedroom to collect items that they require or to use their en suite bathroom facilities. There are times during the day for young people to access their bedroom and this will be supported by staff. However and in order to ensure that young people are enabled to receive the best opportunity for intervention and treatment as well as receive their education access to bedrooms will be restricted to the following times.

.

- After lunch and prior to the afternoon programme, usually 12.30 – 13.00.
- After the unit programme and before evening meal 16.00 - 17.30

18.4 At these times staff will remain in the bedroom area to support young people. At all other times the bedrooms will not be accessible to young people, except in the above circumstances. Parents and carers are

informed of this in the Information Handbook.

18.5 Should young people need to remain in their bedroom area due physical or mental ill health & they are too unwell to join the therapeutic programme this will be care planned for the individual young person & reviewed regularly.

19. Emergency Contingencies

19.1 Emergency mental health cover (during normal office hours weekdays 0900 -1700) will be from the Unit team, both medical and nursing. There will be provision for extra nursing staff to contain extreme behaviour.

19.2 Out of hours (weekdays after 1700 and at weekends) there is the senior mental health practitioner on call, who can provide the unit with immediate advice, Psychiatric/medical first on call cover is provided by the on call Senior house officer/Core trainee 1 - 3 for adult mental health based at the Glenbourne unit Derriford hospital, this person is backed up by the on call CAMHS consultant psychiatrist. All on call personnel can be accessed through Mount Gould Hospital switch board 01752 268011.

19.3 In extreme cases the Unit may request assistance from the police. In such cases The Assistant Director for Comprehensive CAMHS will be informed of this process and a review meeting held by the management team within 48 hours this will be to agree lessons learned. The staff team will be debriefed following any such incident and the young people will be supported through their community group meeting, however, if necessary support for the young person will also be on an individual basis.

19.4 In the event of an absconding young person the parents/carers will be informed as soon as possible. The LSW's Missing Patient Policy will be followed. This lays down the criteria for informing relatives and the police, as well as providing a checklist for action. An incident/accident report form will be completed and a missing persons form.

20. Transfer of Young People to more Intensive Services

20.1 There are occasions when young people will need to be transferred from our care to somewhere more appropriate to their current level of need i.e. a low secure CAMHS inpatient unit or a psychiatric intensive Care Unit, or on occasions to a CAMHS inpatient unit nearer to their home.

20.2 On these occasions we will transfer young people by ambulance staffed with a driver & at least one member of ambulance crew. The unit will provide 2 members of nursing staff to accompany the young person and to facilitate a smooth transfer, this will as a minimum one registered nurse & one health care assistant. Where possible both of these staff will be known to the young person, however where bureau or agency health care assistants are used they must be accompanied by a registered member of

Plym Bridge nursing staff known to the young person. This registered nurse will be responsible for any formal transfer by MHA process i.e. sec 19 transfers.

20.3 Prior to the transfer taking place an MDT meeting is to take place to plan the transfer, including the completion of a risk assessment and risk management plan in reference to the journey and any planned stops. This will include a doctor, administrator, nurse in charge & those staff facilitating the transfer. The plan should include stops if any, provision of food & drink for the journey & any requirement for prescribed 'Regular' or 'As Required' medication for the young person. It is important from this meeting all people are clear, how & when the transfer is to take place. Nursing staff facilitating the transfer should take a unit mobile phone to contact the unit or other services should they require.

20.4 As part of this process staff will include parents and carers as part of the planning and will inform them when the young person has reached their destination. Where appropriate and possible the planning will always include young people.

20.5 It is vital that these transfers take place in the context of a planned, thoughtful & smooth transition to assist with the anxiety that the young person may be experiencing re. such a transfer.

21. Information Strategy

The Unit will have an integrated information system to:

1. Produce information that reflects the actual work done by the Unit.

2. Provide performance data for the commissioners of the service.

3. Support staff through the generation of information to enhance clinical work, facilitate effective Unit management and to promote outcome and quality measures.

4. Access data for clinical and managerial audit.

5. Generate information to support inter-agency and inter-departmental collaboration.

6. Gather information to further research and development in the field of adolescent mental health.

22. Representation and Complaints

22.1 Representations about decisions and actions of the team should be brought to the attention of the Modern Matron in the first instance. They

will initiate any investigations in accordance with LSW policies and procedures.

Access to the Patient Advice and Liaison Service (PALS) and advocacy services for young people will be encouraged.

22.2 Where a complainant is dissatisfied with the findings and proposals of the clinical team this will be referred to the LSW litigation and complaints as per the LSW's policy.

22.3 Complaints
The Unit Manager/Modern Matron for Livewell Southwest has overall managerial responsibility for the delivery of CAMHS and can be contacted at the following address:

Plym Bridge House
4 William Prance Road
Crownhill. Plymouth
PL6 5ZD

Complaints can also be directed to the Customer Services Department

Local Care Centre
Mount Gould Hospital
Mount Gould Road
Plymouth PL4 7QD

Copies of the complaints procedure are available through the Unit for professionals. Service Users and parents/carers will be given information as part of the admissions package.

23. Infection Control.

23.1 The aim of Infection control is to minimise the risk of infection to young people, staff and visitors, by promoting a high level of compliance with infection prevention and control practices.

23.2 At Plym Bridge House we have a team to carry out infection control on the unit. This team consists of:

23.3 The Infection control lead;

- Role is to attend all relevant infection control meetings.
- Cascade any training and information down to the team.
- Act as a positive role model to the team.
- Maintain the infection control board in the reception area.
- Monitor the audits are being done and support the team to ensure that effective systems are in place to reduce risk and the spread of

infections for patients, staff and visitors. (CQC Regulation 12 outcome 8).
- Ensure all staff are aware of LSW Infection Prevention and Control Policies and Procedures.
- Carry out Pandemic flu Mask fit training.
- Ensure that all staff are aware of the Importance of Prevention and Management of Inoculation Injury.
- Give Outbreak Guidance.
- Encourage flu inoculation.

23.4 Staff nurses;

- Carry out the infection control audits on the unit.
- Report to the infection control lead with any concerns.
- To support their peers and junior staff to comply with Infection control.

23.5 Health care assistants;

- Carry out the infection control audits on the unit.
- Report to the infection control lead with any concerns.

23.6 Housekeepers;

- They are responsible for keeping the unit at a very high standard of cleanliness.
- Report and concerns to the infection control lead.

23.7 Occupational Therapist;

- Carries out assessments on personal hygiene, kitchen hygiene with the young people.
- Report concerns to lead.

However infection control is everyone’s business.

In the reception area there is an infection control board. On the board is the following documentation:

- Code of practice: The 10 key principles.
- Unit information.
- Audit reports (Weekly infection control, monthly Hand Hygiene, mattress, duvet and pillow).
- Inoculation injury flow chart.
- Names of the staff on the infection control team.

The board is updated weekly.

23.8 Hand Hygiene.

- Hand wash facilities are provided in the main reception area to enable staff, visitors and young people to wash their hands before entering and leaving the unit to minimise risk and transmission of infection.
- Hand hygiene policy is available on the intranet and in hard copy
- Hand hygiene posters are clearly visible in all hand washing areas.
- All staff are to follow the trusts dress code and be bare below the elbows (where appropriate).
- All staff, young people and visitors are to be given guidance on the importance of hand hygiene.
- Monthly staff hand hygiene audits (results are displayed on the Infection Control Notice Board).

23.9 Cleaning and monitoring schedules.

- Plym Bridge House work closely with Hotel Services to maintain a clean, safe environment for young people, staff and visitors.
- Housekeepers on the unit are responsible for keeping the unit clean. The young people and staff are responsible for keeping the unit tidy., However all staff have a responsibility to clear up any spillages that they observe at the time.
- The nursing staff are responsible for cleaning the unit following clinical accidents, where bodily fluid and matter are involved.
- The young people are encouraged to keep their rooms clean and tidy to minimise risk of spreading infections.
- The housekeepers have daily and weekly cleaning schedules to complete on the unit.
- There are cleaning schedules for the clinical equipment and labels are used to provide evidence of cleaning.
- Mattresses, duvets and pillows are audited for damage on a 3 monthly basis.
- Duvets and pillows are sent away for deep cleaning as soon as a young person is discharged.

The matron's charter is completed by the modern matron on a 3 monthly basis.

23.10 Training.

Infection control training is incorporated into the Induction and annual Mandatory training sessions for every member of our staff.

24. Training

24.1 All staff working at Plym Bridge House should have read the Operational Policy, this is included in the induction process for new staff. Where updates to the policy are introduced, all staff will be informed.

All policies are required to be electronically signed by the Lead Director. Proof of the e-signature is stored in the policies database.

The Lead Director approves this document and any attached appendices. For operational policies this will be the Locality Manager.

Signed: David Furze

Date: 27.03.2014

Appendix A

Therapy Groups

Art therapy

Art therapy is a way of sharing thoughts and feelings without having to speak directly to the therapist. Creating images allows young people to make their own choices and express themselves safely. They do not need to be confident in using art media and are encouraged to explore different materials. Art therapy can be offered both individually and in a group setting.

Art therapy groups

Open group

This group offers a safe space to explore thoughts and feelings through creative expression. This is a non directive group; throughout the session young people are able to choose the art materials they would like to use, join in group conversations, observe others activity and take quiet time. The art therapist encourages personal choice making and supports individuals to engage in a way that feels appropriate for them. The group is about trying things out and exploring different possibilities rather than having a particular skill in art making. Young people may choose to work alongside a peer or with a group facilitator. Sometimes group members work quietly and sometimes ideas, thoughts, feelings and noise are shared.

Art therapist and co-facilitator create images in this group.

Post 16's group

"Stories & Images"

This group has a clear structure and includes the use of "found materials" to support creative work and ideas; a short folktale and an image will be shared with the group each week. The art therapist will read the story at the start of the session; an agreed period of quiet time in which to create images will then follow. Images may be directly related to the story or represent feelings or ideas an individual may have in mind at the time. Images will be explored by the group through a process of turn taking; the artist sharing thoughts of their own image and also having the chance to respond to the work of others in an ordered format. Themes and ideas raised by the story may be considered alongside the personal experiences and beliefs of group members as appropriate.

Co-facilitator creates images in this group.

The psychotherapy group

An adolescent inpatient unit, like adolescence itself can fluctuate from one extreme to another. Paying attention to the life of the adolescent group is important as it allows for shared understanding to come about between children and young people and the adults who care for them within this context. The psychotherapy group is a formal space set aside for the young people, with the assistance of the therapists, to find out more about one another and to explore the experience of being together.

We acknowledge that young people can find listening to and learning from one another more useful than hearing or learning from adults. Some issues can also be better contained and thought about in a group, than in individual approaches. This understanding applies to all group work on the Tier 4 Unit to some extent, but is specifically an aim of the psychotherapy group.

The psychotherapy group operates with minimal structure but is facilitated by a therapeutic couple, currently the Child Psychotherapist and the Clinical Psychologist. It meets once a week and is not open to observers or students. There is a clear policy regarding safety and respectfulness. Within this framework the young people are free to speak about whatever they wish. The role of the therapists is to encourage the young people to link with and think about each other, while paying close attention to and modulating the emotional climate of the group.

There is a strong theory base advocating the usefulness of group work with children and young people. This recognises the developmental tasks of adolescence in which the individual places an increasing priority on relationships outside of the family and with a peer group. In a more traditional psychotherapy group the therapists can gain awareness of group process, including elements of the group unconscious and carefully use this information to address here and now dilemmas facing the group members. Within the Tier 4 Unit this basic structure is modified according to the needs of the group and the individual young people who take part. The in-patient group at the Unit can change very quickly, and the extremes of disturbance experienced by young people can provoke a lot of anxiety. One aim of the group is to provide a means by which these anxieties are addressed safely.

The therapists work closely with nursing staff to think about the population of the group. It is acknowledged that some young people will not find the group helpful and alternative arrangements will be made for them; for most young people this would be a temporary arrangement with participation in the group becoming possible in a short time.

Changes to group attendance will usually be discussed with nursing staff in advance if possible, but may require rapid decision making on the part of the group therapists. The therapists have a clear responsibility to both the group and the individuals concerned to make decisions based upon maximising the

opportunity the group represents, as well as protecting any member from potential harm. There is a clear understanding that communicating concerns is a priority which can override the confidentiality of the group. A culture of sharing concerns and information exists amongst the team as a whole, with acknowledgment of the need for privacy around sensitive information which poses no risk of harm.

The group therapists have a responsibility to alert the nursing team if a young person is distressed and feed back to the nursing team after the group. An entry in the Clinical Notes for each young person is also made by the therapists running the group. In addition the group therapists receive regular supervision with regard to the group in order to develop their practice and process the experience.

Appendix B

Therapeutic Group Programme

Mindfulness group

This group happens once weekly with the Clinical psychologist and the Occupational Therapist co-facilitate this group. The group involves an introduction and discussion about the meaning of, use and practice of mindfulness and how this relates our thoughts and feelings and overall well-being. The group is then invited to take part in Mindfulness exercises and practice. The group lasted approx 45 minutes. Group members (young people) are selected based on their abilities and current difficulties due to the nature of the group, as it requires understanding and a level of commitment to the approach in order to engage in the sessions.

Cooking group (for post 16)

This activity happens once weekly in the Occupational Therapy kitchen. It involves two young people planning for and taking part in cooking lunch for themselves for that day. The Occupational Therapist and nursing staff facilitate this group. This group provides education around healthy eating and taught skills for cooking for those who are over 16 and out of education. Functioning/life skills and ability are also assessed in these sessions for ongoing work and goal setting to improve skills and confidence in this area. These sessions can also be used as preparation for independent living.

Unit tasks:

This is a time for staff to encourage the young people in aspects of daily living including cleaning and tidying their personal areas, laundry and being involved in food shopping tasks. This will be co-facilitated by the Occupational Therapist.

Life skills:

The life skills sessions happen every Monday morning between 10:00 am and 12:30 pm in the school room, lounge or outside/and off the unit.

Life skills is a group for all young people on the unit and consists of a variety of educational, skill based and active sessions to help young people develop life skills and have a good time doing it. An example of some of the topics that will be covered:

Library skills, alcohol and drug awareness, personal safety, internet safety, sexual health education, gardening, food hygiene/cooking, walks, shopping and budgeting.

This is not an exhaustive list. The session will be both on and off the unit and cover a wide range of topics. We will also be inviting in guest speakers to present certain topics.

Activity group outline:

Activity group is an opportunity to do fun activities on and off the unit, to promote social skills, enhance leisure pursuits and offer a chance to be out in the community and try a variety of activities.

For example going to the Barbican, city centre, cinema, bowling, museum, aquarium, geocaching, ice-skating, walks and lots of other great activities depending on what has been chosen on that day.

When staying on the unit for activity group we offer games, have quizzes, do sports in garden, and play games on the play station or Wii as a group, watch a DVD together.

Film club:

Film club happens once a week on an evening. It is an activity that is facilitated by the nursing team. A variety of films are selected to be watched and discuss/reviewed after the group. This group offers an opportunity to see different films and explore film themes, and see Films thought to be iconic or unusual compared with mainstream cinema. All Films are a 12 certificate or under due to the age range on the unit.

Girls & boys activity session:

Girls and boys session runs once weekly on a Monday evening between 18:30 to 20:00. The nursing team facilitates this group with support from OT as necessary. Various activities are on offer that interest both boys and girls, and every effort is made for group to be held separately and with same gender facilitators. Activities include pampering i.e. nails, facials, and feet. Girls and boys personal hygiene session and health awareness related to gender, and a variety of fun and interesting activities, which are planned for and discussed with young people on the unit at time to cater for particular interests.

Post 16 psycho education:

This group is facilitated by various members of the nursing team and is support by OT when necessary. The group happens on Wednesday mornings between 10:00 and 11:00 in the group room or lounge. The session consists of both educative and skill based sessions covering a variety of topics related to Post 16's. For example sexual health, vocational planning, drugs and alcohol

information, life skills work, anger management and personal safety etc.

Art & craft group:

This group occurs in the group/art room or in the garden. This group is facilitated by nursing team and OT. It provides an opportunity for creative activity in a relaxed environment. This is an open group and young people are offered support with an ongoing art/craft project or given time to learn a new creative skill.

Community group:

The community group is held every morning in the lounge between 9:00 and 9:45. It is a group for all young people who are staying in the unit. It is a place for young people to raise issues, concerns and their experiences in a group setting. The group is lead by two staff members.
The group is also a place to organise/plan for the day. To discuss appointments or visitors young people may have that day, and to welcome new comers to the unit. What is happening today on the group programme.

The general rules for community group are as follows (these are reviewed on a regular basis within the group in reference to the current cohort of young people):
(Decided by young people)

- Respect other people
- Listen to others
- Don't talk over others
- If you are struggling seek help from a member of staff
- No music or TV
- Try to focus on group topics
- Don't disrupt the group if you decide not to be involved
- Whatever is said in community group is dealt with in the group, and stays in the group it should not be brought up during the day.

*t times it may be necessary to call a community group at other times in the day to discuss issues on the unit that may need to be resolved.

Risk assessment:

Currently the unit uses an individual risk assessment, which is completed when young people go off the unit both as a group and as individuals. This individual assessment is currently being reviewed and updated. There is also a need for a unit risk assessment to reflect risk of activities and environments off the unit, which is currently being developed.

Plym Bridge House Adolescent Unit Protocol: Activity Group

Group overview:

The activity group provides a weekly opportunity for the young people to engage in a group based leisure interest. There is opportunity for the young people to develop/maintain their leisure interests and demonstrate social skills within the peer group and wider community. Young people will be encouraged to take responsibility to plan and organise activities with staff input and take some responsibility in the community to enable young people to practice their social and independence skills.

Criteria:

All children and young people on general observations are eligible to attend. Young people on intermittent observations who also have an agreed multidisciplinary care plan for community therapeutic groups are eligible to attend.

1. The young person's behaviour has been assessed to be manageable within the group situation (i.e. a risk assessment has been completed, which indicates they can remain safe to him/herself, others and the environment within the group setting and/or using the milieu in question).

2. If the young person has made any threats to deliberate self-harm/commit suicide or has stated clear plans of intent in past 24 hours, the Consultant at Plym Bridge House unit must review them prior to group starting. (Clinical decision can be made if reviewed by Modern Matron or Deputy Unit Manager/Clinical Team Leaders). This is so that the group leader or facilitators can update the group and individual risk assessment documentation before the group session. The group leader must also be in agreement with the young person attending the session after the Consultant review.

3. If a young person has been verbally/physically aggressive or violent in past 24 hours, the Consultant at the unit must review them prior to group starting. (Clinical decision can be made if reviewed by Modern Matron or Deputy Nurse Manager). This is so that the group leader or facilitators can update the group and individual risk assessment documentation before the group session. The group leader must also be in agreement with the young person attending the session after the Consultant review.

4. For any young person detained under the Mental Health act, Section 17 Leave Forms must be completed and valid to cover the nature of group, time off unit, date and level of support.

5. Young people on intermittent observations who are risk assessed as

appropriate can attend with consent of the Consultant/Modern Matron or Deputy managers.

Contraindications:

1. Young people on continuous observations will be excluded.

2. Young people who have been suicidal/or used deliberate self-harm in past 24 hours and not reviewed by unit Consultant will be excluded.

3. Young people who have been aggressive/violent in past 24 hours and not reviewed by unit Consultant will be excluded.

4. Risk assessment would indicate that the young person is a risk to the safety of him/herself, others and the environment within the group setting and/or using the milieu in question.

5. Section 17 Papers that are; incomplete, not specific, not valid.

Aims:

1. To encourage young person to develop and maintain their leisure interests.

2. To provide opportunity for young people to practice good social skills in a group environment and increase their sharing and co-operative behaviours.

3. To enable the young people to develop prevocational and task performance skills, such as planning ahead, making requests, focussing on the task and completing projects satisfactorily.

4. To provide opportunity for young people to continue to be part of a local community.

Group structure and risk assessment:

The group will involve taking young people off the unit for various leisure activities both using local facilities and more rural pursuits.

A risk assessment of the environment has been completed for both walking based, rural activities and for leisure based facilities pursuits. These risk assessments highlight the risks and management strategies and compliment the use of Individual risk assessments when leaving the unit.

When an activity has a more specific environmental risk then these general assessment will be individualised i.e. rural pursuits or coastal activity.

However, for more active outward bounds activities i.e. sailing, River Dart adventure park, tobogganing etc., we use the facilities own risk assessment of activity we are purchasing and not our own.

Individual risk assessments for therapeutic groups must also be completed for each young person prior to each activity group session. Copies of these forms are in nursing office and on 'M' drive under Plym Bridge House folder as Individual risk assessment for therapeutic groups.

The group will be held on Thursday afternoons between 14:00 and 16:00. However, there is flexibility in this if the day trip is organised in advance.

Appendix C

Protocol for all therapeutic group outings

All Y.P participating in off unit group activities must have a completed individual risk assessment.

The purpose of this assessment is:

1) To reflect current risk and current presentation.
2) To be risk aware and think through management plan for individuals and as a group of staff. To think about allocating staff to Y.P if necessary before leaving the unit.
3) To have a current description of clothing for the AWOL procedure.
4) To highlight physical, environmental and mental health risks which can be different from that on the unit.
5) To also be used as positive risk taking assessment with individuals for particular activities, not just for group settings exclusively, as risk and presentation indicates.
6) To be completed and entered as a Daily Record Activity (DRA) on to the e-PEX system as agreed with the risk management Department.

Appendix D

Body Searches of Young People

When considering undertaking a body search of a young person Plym Bridge House Staff should follow this process:

1. Body searches of young people should be a last resort after **All** other avenues have been explored to persuade young people to give up articles that staff are concerned that are being harboured/concealed, including continuous obtrusive observations.

2. Prior to any body searching, staff should be concerned that the article concealed is potentially very dangerous to the young person or others physical well being.

3. Prior to any body search, during the hours of 9:00 am to 5:00 pm Monday to Friday, permission should be sought from the consultant or senior nurse on the unit. Out of these hours the senior nurse/mental health practitioner on call should be contacted.

Appendix E

PLYM BRIDGE HOUSE ADOLESCENT

INPATIENT UNIT

Food Hygiene Policy

Introduction

This policy sets out the general standards, which are to be aimed for in a therapeutic food preparation area. It specifically applies to the Plym Bridge House Unit at 4 William Prance Road, Plymouth

This policy aims to:

1. Provide practical advice and guidance to ensure that uniform standards are achieved.

2. To act as an information base for food hygiene training exercises.

3. To be a readily accessible reference document for the day-to-day use of all persons involved in the preparation of food.

An abstract of this policy will be displayed in the kitchen area for easy reference.

Food handling staff will be required to sign that they have read and understood the contents of this document.

Food hygiene training

All milieu staff who work in the Plym Bridge House inpatient unit are food handlers. The minimum requirement is that they be trained to CIEH intermediate food hygiene certificate level. New staff, as part of their induction, will receive a basic introduction to food handling and hygiene and will be sent on an intermediate food hygiene course as soon as is practicable.

The nurse in charge of each unit will be trained in advanced certificate level and will provide refresher training for all food handling staff on a regular basis. The issue of food safety will be raised on a regular basis at UMT meetings.

Ongoing monitoring of practice

The nurse in charge will also implement regular kitchen audits in cooperation with the LSW's Environmental Health and Safety advisor.

Daily and monthly checklists will be completed. See appendix.

Records of staff training will be kept in personnel files and regularly updated by the nurse in charge.

The unit will devise a method of noting/logging general food hygiene problems on a day-to-day basis specifying the action taken.

Personal hygiene rules

1. Food handlers must **<u>not</u>** wear jewellery (including watches) other than wedding rings and sleeper earrings.

2. Nail varnish must not be worn. Nails must be kept short and clean.

3. Long hair must be tied back.

4. Disposable clean protective clothing must be worn by personnel, including visitors, in all food hygiene areas. Protective clothing must be changed daily.

5. Food and drink must not be consumed in any food area except dining rooms and designated staff rest areas.

6. Cut and abrasions must be covered with clean, coloured, waterproof dressings.

7. Outdoor clothing and personal effects must not be brought into any food area, except designated changing rooms.

8. Food handlers must wash their hands with antibacterial hand wash:

   a) on entering the kitchen
   b) after handling raw meat, poultry, fish or vegetables
   c) after visiting the toilet
   d) after sneezing, smoking, coughing, or using a handkerchief
   e) after handling refuse
   f) before handling cooked foods
   g) as often as possible during the working day
   h) before and after any cleaning procedures
   i) before and after any meal or beverage breaks.

9. When tasting foods a clean spoon must be used for each tasting.

10. Smoking is strictly forbidden in any food preparation area.

11. Personnel are strictly forbidden to sit on the work surfaces.

Please adhere to these guidelines.

Tell the nurse in charge if you cannot follow these guidelines.

Patients suffering from infectious conditions

Patients with ear, skin, nose, throat or bowel infections must be excluded from kitchen and food storage areas. They are not permitted to take part in the preparation of food or in its service.

Patients with boils or septic cuts **must not** handle food.

The food premises and facilities

Floors: Must be durable, non-absorbent and without cracks or crevices.

Walls: Behind food preparation surfaces or equipment must be capable of being cleansed and disinfected to a height of at least 1.8m. Gaps around sheet materials must be sealed to prevent dirt ingress.

Ceilings: Should be smooth, hard, impervious and easy to clean.

Windows: Fly proofing is required for opening windows. All windows must be constructed to enable regular easy cleaning.

Doors: Especially handles/finger plates, must be smooth, impervious and capable of disinfection.

Lighting: Levels should comply with current Health Building Note 10.

Ventilation: As per Health Building Note 10. (Adequately vented to an external air supply). Extractor hoods and systems should be positioned above heat or fume producing equipment, i.e. cookers or refrigerators. Extractors should be fitted with removable filters capable of being cleaned.

Work surfaces: Joins between work surfaces must be sealed and worktop/wall junctions curved to facilitate cleaning and disinfection.

Food preparation areas and equipment

No wooden equipment is to be used

All equipment should be moveable to ensure thorough cleaning.

Chopping boards will be made of polypropylene and of a size to fit in the dishwasher. They must be disinfected between uses and washed in the dishwasher at the end of each day. Knives will have moulded plastic handles, which will withstand disinfection in the dishwasher.

The unit manager or their deputy is responsible for making a daily check on the condition and correct use of all equipment in the kitchen.

Kitchen equipment must be able to fit in the dishwasher and withstand being disinfected to a temperature of 82°C.

Sinks

Sinks should be:

- Easy to clean.
- Have hot and cold mains water supply.
- Be separate and labelled for “Food Preparation Purposes Only”.
- Cleaned and disinfected thoroughly after use.

Hand washing facilities

- Hand washing facilities must be readily accessible in **all** food areas.
- Have warm water (suitably controlled temperature).
- Have bacterial liquid soaps and dispensers.
- Have disposable paper towels and foot operated, lidded bins.
- Have an adequate number of signs **“hand washing only”**. (Wash hand basins must not be used for any purpose other than hand washing).
- Hands must be washed before food preparation starts and after handling refuse or swill and always after visits to the WC.

Toilets

Toilets must be:

- Well lit and ventilated, have suitable wall covering and floors.
- Have washing facilities as before.
- Have **“now wash your hands”** signs.
- Have facilities for the hygienic disposal of sanitary ware.

Food handling procedures

Purchasing and Deliveries

Goods must be checked on arrival for:

- Condition and damage

- Relevant dates for use
- Pest damage or infestation
- Temperature

  The maximum allowable temperature on delivery are:

  Frozen foods - 9°C
  Other chilled foods 7°C

- Damaged, leaking, rusty or "blown" canned goods should not be accepted.

Purchases

All food items must be brought from a reputable supplier/source, i.e. Sainsburys, Tescos, Morrisons.

Chilled or frozen foods will be transported in cool bags and purchased last.

Storage and Stock Rotation

The following rules must be followed:

- "First in, first out" principle.

- No food must be used after the "use by/best before" dates have expired.

- Dry food products must be stores in pest proof containers.

- Goods must be stored off the floor.

- Weekly checks on the condition and dates of frozen food must take place.

- Drugs, blood for transfusion, clinical or medical specimens, must not be placed in the food refrigerators.

- Staff food must not be stored in the refrigerator and should not be brought into the food area. Chilled and frozen food must be stored at the following optimum temperatures.

  Frozen foods -18°C
  Chilled foods 0°C to 5°C

- Twice daily checks must take place on the chilled foods.

- There must be separate (marked) refrigerators for raw and cooked foods.

Canned goods

All instructions regarding storage must be strictly followed.

Best before dates must be strictly observed.

Refrigerated storage

The following rules/procedures apply to refrigerated storage:

- The cabinet should be provided with temperature measuring equipment to +/- 1°C. Thermo sensors must be located in the warmest spot and the temperature must be checked and recorded twice daily.
- Thermographic temperature recorders must be checked DAILY and graph paper changed when necessary.
- The cabinet must be labelled with its intended use, the current operating temperature and the emergency procedures (including telephone numbers).
- It is recommended that separate refrigerators must be used for cooked and raw products.
- Salads, sandwiches and cold meat foods must only be kept in machines capable of maintaining an air temperature of 0°C to 5°C.
- No hot foods are to be placed in the refrigerators.
- All foods should be covered.
- The doors should be opened as little as possible and not left open.
- The refrigerators should be defrosted/cleaned weekly.
- Food items should be suitable spaced to allow cool air circulation and prevent overstocking.

** **Raw and cooked foods must always be kept separate** **

Freezer storage

The following rules of procedures apply to freezer storage:

- The temperature measuring apparatus should be as per the refrigerated storage.
- The recordings and recorders should be as per the refrigerated storage.

- The units should be labelled with their intended use.
- Cooked and raw products should be kept in separate freezers or alternatively in separate sealed containers.
- All foods should be covered.
- The doors should be opened for as little time as possible.
- Freezers with automatic cycle defrost should be cleaned every 3 months.
- Freezers with manual defrost should be defrosted and cleaned monthly.

Food preparation

The following rules/procedures apply to food preparation:

- **Raw poultry will not be used.**

10 working rules for food handlers

1. Keep raw and cooked foods separate.
2. Use separate work surfaces, utensils, containers and equipment for raw and cooked foods.
3. Keep perishable foods, especially cooked meats under refrigeration.
4. Ensure that initial cooking reaches at least 70°C and that cooked foods are kept above 63°C or cooled to below +3°C within 90 minutes.
5. Keep foods covered.
6. Do not touch foods unless it is absolutely necessary.
7. Ensure that frozen foods are thoroughly defrosted before use.
8. Use stock in rotation.
9. Clean as you go.
10. Keep lids on dustbins.

Cooking distribution and service

The lowest heating point within the food must reach between 70°C for at least 2

minutes or best practice 90°C for at least 6 seconds.

Temperatures of the food should be monitored via probes and recorded if the food is to be consumed by other residents.

Raw food/containers must not be placed on cooked food work surfaces unless disinfected first.

Hot food must remain above 63°C until service.

Ice cream must never be served if temperature rises above –2.2°C.

Food prepared by residents/clients should be consumed within 90 minutes of cooking and **must never** be reheated conventionally or in microwaves.

Food prepared by residents/clients should be consumed by themselves alone and not shared with anyone outside the group.

Waste food and refuse

Waste food and rubbish should be disposed of using a lined foot operated refuse container. These containers must be emptied **at least once per day**. At the end of the therapy sessions all waste food, empty bottles and refuse should be removed from the food room.

Cleaning

All equipment and chemicals must be stored in the "domestic" cupboard away from the food area and the cupboard must be locked at all times. Chemicals will be stored in accordance with the COSSH regulations.

Cleaning methods

Dishes and pans must be cleaned in a mechanical dishwasher capable of a detergent wash with water at 50°C to 70°C and having a final rinse water temperature of 82°C or above for at least 2 minutes.

The correct procedure for machine use must be followed including rack stacking, debris removal, drying via evaporation etc.

It is recognised that, as part of the therapy process, the correct method of washing up and use of domestic tea towels may be taught. All food preparation equipment, utensils and crockery should be thoroughly washed in very hot water plus detergent and either left to air dry or dried with a **clean** tea towel. It should be emphasised that tea towels may only be used in this situation for drying equipment, utensils and crockery, which are restricted to the therapy area. Any items dried in this way will be washed afterwards in the dishwasher to ensure disinfection, at the end of the day.

Work surfaces are to be cleaned after the floors.

The following procedure should be followed:

1. Remove debris.
2. Detergent + hot water wash.
3. Rinse (clean hot water).
4. Disinfectant (+ contact time).
5. Rinse (clean hot water).
6. Evaporate dry.

Cleaning schedules

These must be provided by the Hotel Services Manager; specifically written for the individual kitchen in question. A copy will be kept in the unit for reference. The schedule must specify:

- **What** is to be cleaned?
- **Who** is to or has cleaned "it"?
- **When** is to be cleaned and how often?
- **How** is it to be cleaned?
- The **chemicals** to be used for cleaning.
- Any **safety precautions**, i.e. protective clothing to be worn (goggles, gloves) and storage of chemicals.

The work schedule will be displayed on the kitchen wall for easy reference.

Areas marked in green ink are the responsibility the domestic service staff. Areas not marked are the responsibility of the unit staff.

The cleaning schedule will be monitored by the Domestic Supervisor by the use of a daily checklist.

Pest control

Preventative measures:

- Doors should be self-closing with metal kick plates.

- Opening windows to be fitted with fly screens.

- There must not be gaps around the pipes or other services passing through walls or floors.

- Access covers for drains etc., must be in good repair and securely fitted.

- All goods must be regularly examined for signs of infestation.

- All sightings/signs of pests must be reported to the authorised/monitoring officer as per the Pest Reporting Structure.

Appendix F

Television and DVD use

Television use (personal televisions are not permitted)

The lounge television is to be used only within certain times:

1. On weekdays from 4:00 pm until bedtime.

2. During the day/evening at weekends.

3. Staff to monitor content of programmes especially after 9:00 pm – decide on appropriateness to client group.

All of the above are at nursing staff discretion.

Video/DVD use – recreation

1. Rating guidelines are to be adhered to.

2. Only Certificate 12's and under are allowed. This also applies to cinema trips.

3. Viewing times are limited by TV use.

4. Any video tapes purchased for the unit to be kept locked away by staff – not left out with the video.

5. TV use takes priority over DVD use.

6. Staff to reach agreement about who will choose and return video/DVD. Return date recorded in unit diary.

Games Console within the Games Room

Weekdays after the group programme at weekends open access by negotiation with the staff for reasonable amounts of time taking appropriate breaks as advised.

Appendix G

Ground rules for Young People

Boundaries

Young people will not have free access to bedroom areas during the day unless accompanied by a member of staff retrieve possessions from their room, this is to provide structure to the day and encourage participation in therapeutic group program and education. Outside of this there are specific times during the day set aside for all young people to access their bedrooms for an agreed period of time each day in order to have privacy and a space for relaxation, this is currently after lunch prior to the resumption of the group programme & between 16.30 & 18.00.
Young people are not allowed in each others bedrooms.
No alcohol, un-prescribed medication, illegal substances, cannabis or legal 'clubbing substances' or harmful objects to be brought in to the unit or used.

Do not damage the environment, self or others by any means, including violent ones.

Smoking

Plym Bridge House and its grounds is completely Non-smoking.

Visiting

We encourage visiting between the following times 16:00hrs - 21:00hrs weekdays and open visiting at weekends but generally before 21:00. However we appreciate that due travelling times and working arrangements this will not always be possible and therefore the unit will be flexible around visiting young people's visitor's requirements.

Parents, immediate family and agreed friends can visit the unit. Visitors are encouraged to inform the CAMHS Tier 4 unit prior to their visits; therefore ensuring young people continue with their therapy/education program, and they are not out on unit activities, rooms are booked and adequate arrangements are made to ensure the young person is supported prior to any visit. Visits are to be held in the interview rooms and should avoid communal areas to protect other young people's confidentiality.

Offices

No young people in team and staff offices.

Outings

Young people must ask staff before leaving the unit and may only go unaccompanied if it is part of their planned care. Young people are not to leave the unit without permission.

Bedtimes

Weekdays - All young people are to be in the bedroom area getting ready for bed by 10:00 pm and lights out at 11:00 pm. Weekends – To be in the bedroom area by 11:00 pm and lights out to be at nurse's discretion but no later than Midnight.

Kitchen Rota for group work (setting the tables, washing up and prep meals) to be decided each week by young people and staff. Wash own cups in between meals.

Mealtimes Everyone to attend and to remain until the end of the meal, All young people to be encouraged in helping to clear the table at the end of the meal.

Telephones A cordless telephone is available to young people to make calls.

Mobile phones are not permitted on the unit, if brought into the unit they should be handed into the office for safe keeping.

Laptops/Gaming Devices/MP3's etc Young people can bring and use these devices on the unit, however they must not be able to connect to the internet or contain cameras.

Mornings Weekday – 7:00 am wake – 8:00 am breakfast.
Weekend – 9:00 am wake – 10:00 am breakfast.
Make/tidy bedroom before breakfast.

Lending/ Borrowing Young people are discouraged from lending/borrowing to/from each other. This includes money, clothes and personal possessions to avoid damage, loss and disagreements.

Valuables Clients are advised not to bring valuables to Plym Bridge House as the LSW cannot be held responsible for loss or damage.

Money should be handed into the office for safe-keeping. Each young person will be provided with a patients' money book to document and sign the correct amount of money in, this will be signed by a staff member and the young person. All monies will be kept safe until returned on discharge and purchasing items when out on unit activities.

A personal locker will be provided if necessary to store any valuables such as laptops etc.

Sharps/Aerosols These items are to be handed into the nursing staff for safe-keeping.

Appendix H

Plym Bridge House - Smoking Guidelines

These guidelines are to be used in order to manage smoking for young people during their stay on the unit.

When a young person is admitted to Plym Bridge House and wishes to continue to smoke the following guidelines should be adhered to. These guidelines were developed following consultation with service users, Plym Bridge House staff, Interim Director for Children and Families and the Livewell Southwest Risk Management Department :

- If a young person smokes staff should always offer them the opportunity to use the LSW's Stop Smoking Service. If required, nicotine replacement can be prescribed as appropriate.
- Immediately on admission all smoking materials, including lighters, are to be handed into staff and for staff to store them appropriately within the nursing office. Staff from this point must ensure this is managed safely.
- Young people are able to have **up to <u>6</u> cigarette breaks a day**. This is as per the cigarette break rota form.
- Young people are not permitted to share or provide other young people with cigarettes.
- Young are responsible for arranging the purchase of their own cigarettes and not request that this is done by other young person's parents/carers.
- Young people, at the nurse in charges discretion, may either go out to the designated smoking area, either individually or in small manageable groups.
- Young people will need to wear shoes or slippers whilst outside of the building otherwise without such they will be unable to go out.
- Young people will be given their smoking materials in order to make a cigarette prior to them going for their cigarette break. Smoking materials will be given to the young person in the dining area. Cigarettes will not be rolled in front of non-smokers. The making of cigarettes can be done in the privacy of the dining area. Lighters will remain with the member of staff accompanying the young person(s) until they arrive at the designated smoking area. The lighter then can be handed to the young person in order that they may light their own cigarette away from staff members. The lighter must be immediately returned to the staff member. Should there be any issue with the lighter not being returned to the staff member, then there are no further cigarettes until the lighter is returned. This is a Fire Safety and Health & Safety issue.
- The designated smoking area is in the area outside, directly opposite the kitchen and is accessible via dining area.
- Young people on smoking breaks must '**<u>not'</u>** access the smoking area via the girls lounge.

- Staff can facilitate cigarette breaks by either sitting outside with the young people, sitting on the opposite table to the designated smoking area or preferably by viewing the young people behind a closed door in the dining room.
- Young people are able to have their first cigarette of the day between the hours of **08:45** and **09:05** (however this can be an hour later on Saturday & Sunday mornings as young people get up an hour later at the weekend).
- Young people must have their last cigarette of the day before **21:00** hours, however, this can be an hour later if necessary on Friday and Saturday evenings, as young people can retire later to bed on these days.
- At weekends staff should facilitate cigarette breaks an hour later in the morning in order to fit in with the units weekend programme.
- Young people who are on observations should only be allowed to have cigarettes if appropriately assessed as safe to do so, following a nursing risk assessment. If young people on observations are not assessed as to be safe then unfortunately they will be unable to have a cigarette. The young person will then be reassessed for their following cigarette break.
- Young people will be permitted to smoke on day long group activities. On such occasions young people will smoke separately from their peers. Smoking materials will remain with staff at all times. Therefore young people will adhere to the amount of permitted cigarettes as per the above guidelines, whilst in the company of PBH staff. If activities are planned during a smoking break staff must adopt a common sense approach and consider such options as facilitating an early/delayed smoking break.
- Should young people have unescorted leave from the unit, they will be given their smoking materials to take with them.
- When a young person goes on home leave all smoking material will be returned to them.
- Young people are to tidy up after smoking, i.e. they must keep the smoking area clean and extinguish all cigarettes in the bin supplied. Young people will need to take turns in cleaning the smoking area, i.e. frequently emptying cigarette bin and replacing sand.
- If a young person is admitted to the unit and is a non-smoker and decides to start, this will **<u>not</u>** be facilitated.
- Young people under the age of 16 will only be able to smoke if their parents are aware and have given their consent.
- Should the unit be unsettled when a smoking break is due, staff must assess the situation and proactively decide whether to delay or forgo the cigarette break until the next break is due.

These guidelines will be reviewed on a regular basis and updated if necessary.

Appendix I

Plym Bridge Garden Guidelines

Risk	Safety Measures
Staff being isolated	Should not be less than two members of staff in the garden at any time unless team decide that a 1:1 situation is safe.
Slips, trips and falls. Path and grass may be wet or muddy.	Staff need to visually assess the area prior to going out into the garden.
Tables and benches to be used appropriately.	Staff to ensure that young people do not climb on them.
There is a blind spot behind the shed where young people could hide or abscond over the fence. The garden is divided by the shape of the building making observation from one part of the garden to the other impossible.	Staff to be aware of young people's whereabouts in the garden at all times. Young people will not be in the garden on their own.
Garden tools	All tools will need to be individually risk assessed and once in use under supervision at all times.
Types of plants.	All plants will need to be non poisonous. If considering plant containers or pots they need to be heavy enough that two people would have to move them.
Trees.	Need regular pruning. Observe any growth that could be used as a ligature point or any damage.
Fence	Staff to be aware that it is possible to climb over the fence and there is a risk of getting splinters or fragments could be picked off. Staff to be aware that all fences could provide a potential ligature point

Appendix J

ANTI-BULLYING PROTOCOL

Rationale

All children and young people, have the right to go about their daily lives without the fear of being bullied. Bullying can take place anywhere in the community, in any organisation and between anyone. Therefore, addressing bullying is not just an issue for institutions, but for parents and carers, all organisations working with children and young people, all staff working within these organisations and the wider community.

Plym Bridge House is committed to providing a caring, friendly, safe and supportive environment for all children and young people, parents and carers and also staff, and therefore to effectively address bullying so that the incidence of all forms of bullying is minimised.

It is the responsibility of all members of staff to:

- Promote a secure and safe environment free from threat, harassment or any type of bullying behaviour
- Take positive action to prevent bullying from occurring
- Implement procedures to deal with bullying (using these guidelines)
- Show commitment to overcome bullying by striving to maintain a bully-free environment

When bullying is brought to our attention, prompt and effective action must be taken. Children and young people exhibiting bullying behaviour need to be held accountable for their actions, by being given opportunities to learn about its impact on others, to make efforts to repair damage they have caused and to change their behaviour. Those on the receiving end of bullying need to be confident that the bullying will stop and that they can feel safe in their own environment; they may also need help in restoring the power balance between them and the person or group of people responsible. All young people affected – whether they witness or exhibit bullying behaviour – need appropriate emotional and practical ongoing support during and following incidents of bullying. This can take place in many different forums at Plym Bridge House it would be typical to use: community group, psychotherapy group, individual care planning and individual therapy.

Definition of Bullying

The Anti-Bullying Alliance state:

“Bullying is the intentional (physical or emotional) hurting of one person by another, where the relationship involves an imbalance of power. It is usually repetitive or persistent, although some one-off attacks can have a continuing harmful effect on the victim.”

People perceive bullying differently, and, what one person considers a traumatic

bullying experience another may feel is harmless and playful. Therefore it is important to make both staff and young people aware that bullying can take many forms and have different effects on different people. The approach adapted for Plym Bridge House is based upon encouraging bullying interactions to become openly discussed and seeking those involved and other young people to contribute to the resolution of such problems. This process is designed to undermine the secrecy and intimidation that can often be involved in bullying, and contribute to the development of a culture which is not tolerant of, nor conducive to bullying.

Bullying Behaviour

Bullying can take many forms, including:

- **Verbal** Name calling, insults, jokes, offensive language or comments, including threats, innuendo, teasing, taunting, bragging, ridicule
- **Physical** Unprovoked assaults such as prodding, pushing, hitting or kicking, shaking, inappropriate touching, blocking the way, capturing, contact involving objects used as weapons
- **Social** Humiliation through exclusion or rejection by peer group, 'blanking', spreading rumours, gossiping, peer pressure to conform, using difference as dividing factor
- **Cyber** Via the internet, email or mobile phone, e.g. text messages, phone calls, pictures/video clips ('happy slapping'), chat rooms, instant messages or posting on websites or message boards
- **Non-verbal** Staring, throwing dirty looks, gesturing, body language, invasion of personal space, silence, spitting, stalking, playing mind games
- **Provocative** Inciting others to behave in a threatening way, racist, faith-related, sexist or homophobic, special educational needs and disability related
- **Other** Extortion, blackmail, hiding or interfering with personal property, forcing to take part in embarrassing initiation rites or humiliating acts, seeking sexual favours

How to Manage Bullying

These steps can be followed if you are approached by a young person reporting a bullying incident. They can also be followed should you witness a bullying incident. If you witness bullying the first step to take is:

Stop it immediately and talk to the young people involved to decide if the incident is considered bullying.

- Ensure all parties alleged in the bullying incident aren't left alone together
- Listen and support the young person as they tell you what has happened
- Provide feedback to the team immediately
- Get the bully and victim together to come up with a solution

- Raise the issue in community group (which can be called at any time)
- Record all information in the clinical notes
- Monitor the situation and repeat the process if necessary

In more detail:

- Provide individual time and support and be supportive while listening to the young person when telling you what happened
- Acknowledge how difficult it might have been to talk to you, and explain that you will share this information with the team

- Set up a meeting between the alleged bully and victim
- Decide on the most appropriate person(s) to facilitate the meeting – try to have one member of staff to act as a support for each young person
- The aim of the meeting is to help the victim and bully to gain insight into each other's feelings and perceptions. It is important to keep the meeting focused on the task
- The staff members present should start by explaining the purpose of the meeting and establish the boundaries (e.g. confidentiality, allowing each other to talk without interruption, listening to each other, not ridiculing each other etc). If there are no suggestions for boundaries then give examples
- Ask each young person to give his/her account of the incident, starting with the victim and then the bully. Ask them to give examples of feelings and thoughts. Encourage them to talk to each other instead of using you as the mediator. Remind them of the agreed boundaries as the need arises. Point out misperceptions supportively as they come up
- Explain that the meeting will be fed back in the next community group to illicit how this made other young people feel and how they can best support each other
- Discuss expectations around conduct and behaviour on the unit (i.e. being polite and respectful, not name calling etc)
- If you feel that the meeting is becoming unproductive or unsafe - explain your observations and offer the opportunity to adjourn the meeting and come back to it later. Consider each young person's safety needs when ending the meeting
- Regardless of how the meeting ends - give feedback to both young people, indicating that discussing the problem together highlights their commitment to solving it
- The victim and bully may need to meet more than once to fully explore their difficulties. Offer a follow up meeting if you feel that it would be appropriate
- Do not expect to always achieve a solution – aim to raise awareness of how they have made each other and the other young people feel and the unit culture (caring, friendly, safe and supportive)

- In the community group encourage the other young people to offer their thoughts and feelings around what has happened. This is to illicit other young

peoples' values and beliefs, to challenge each other and learn from each other to promote an anti bullying culture

- End the community group on a neutral grounding, so as not to side with anyone. Offer praise and support to the victim and bully and thank the other young people for their input

- Information should be fed back to the team and where appropriate specific care plans will be amended or written if necessary

In cases where a person continues to bully other young people & all of the above do not resolve the situation, the senior clinical team, (Consultant Psychiatrist, Clinical Psychologist & Modern Matron), would need to consider the viability of the young persons continued admission at Plym Bridge House balanced with their continued need for treatment. In extreme cases this could involve some time out from the unit to their home base, consideration for treatment at another unit or discharge to the care of their community team. All of the above would require the senior team to involve the community team in considering any of these decisions.

Appendix K

<u>Outline of a day at Plym Bridge House</u>

Monday – Friday

0730	Young People woken to begin day, Young people to complete their morning routine.
0815	Breakfast in dining room (half hour later start during school holidays).
0910 to 0950	Community Group (Group Room) young people will have limited access to other rooms until after Community Group (flexibility required if a young person is distressed or have severe symptoms of them being mentally unwell).
1000 to 1100	School/Group program (including post 16) begins. There is an expectation that all young people should attend a variety of groups. These will take place in the group room, education room, O/T room, art room, music room or garden.
1100 to 1130	Break for snack (dining room).
1130 to 1230	School/Group program (continues).
1230 to 1300	Break for lunch, all young people to eat in the Dining Room or the O/T kitchen if they have been participating in individual/group cooking activity or if it has been arranged young person to have a meal with their family as part of their care plan.
1300 to 1400	Chill out time (extra unit activities may occur). Young people could use chill out time to relax, have a period of 1-1 time with their allocated staff member. Young people may wish to have supported access their bedrooms at this time. The garden will be available to young people with support from staff, dependant on the weather.
1400 to 1600	Group program facilitated by staff some activities may occur off site with staff support.
1600 to 1800	Chill out time at this point young people can have supported access to their bedrooms and access to all rooms in the main living areas which will be supervised as required. The garden will be available to young people with support from staff, dependant on the weather.
1800 to 1830	Dinner in the dining room.

1830 to 2200	Chill out time, young people to access areas in the living areas, lounges, games room, chill out room, 1-1 time and access to therapy rooms, only with supervision. The garden will be available to young people with support from staff depending on weather and available daylight.
2200	Access to bedroom areas (however young people may retire to bed early although this will be dependant on individual/group need). Friday evening access to bedroom areas at 2300.
2300	Encourage young people to settle to sleep.

Saturday and Sunday

0900 to 0945	Young people woken. Young people to complete morning routines
0945 to 1015	Breakfast in dining room .
1015 to 1115	Flexible chill out time, young people to access areas in the living areas, lounges, games room, chill out room, garden, 1-1 time and access to therapy rooms, only with supervision. Staff and young people decide on activities for the day.
1115 to 1130	Break for snack (dining room).
1130 to 1230	Flexible chill out time, young people to access areas in the living areas, lounges, games room, chill out room, garden, 1-1 time and access to therapy rooms, only with supervision. Staff and young people to decide on activities for the day.
1230 to 1300	Lunch, all young people to eat in the Dining Room or the O/T kitchen if participating in individual/group cooking activity, or if it has been arranged young person to have a meal with there family as part of their care plan.
1300 to 1800	Flexible unit activities (as above).
1800 to 1830	Dinner (dining room).
1800 to 2200	Flexible unit activities (as above).

2100 to 2300 — Access to bedroom areas (young people may wish to retire to bed earlier this will be dependant on individual/group need).

2330 — Encourage young people to settle to sleep (2300 on Sunday evening).

Appendix L

Young People's Information on Supportive Observations

Introduction

We appreciate that admission to an inpatient setting could be distressing for you. You may have been admitted to the ward to maintain your safety or monitor your mood /mental state. You may have agreed to come into hospital as an informal patient, for some young people the admission to hospital is voluntary, i.e. you have agreed to come into hospital, but it may be against your will requiring detention under the mental health act, which may further add to your distress.

It is essential to ensure that your stay on the ward is therapeutic providing the clinical team with the best opportunity to care and treat you, observations will play a vital role in maintaining your safety. We will notice if you or another young person becomes distressed and agitated, and will use supportive observations to help keep you and other young people safe.

What are observations? Observations are conducted by a member of staff, they include the member of staff checking: you are safe, where you are, what you are doing, how you present, i.e. do you look upset or happy. They will also notice things like interactions with others on the ward, levels of concentration etc. Observations can also involve accompanying a young person off the ward to go in the garden etc, to help maintain safety. Observations are a time when the member of staff may also ask you how you are and can be a useful way of engaging with you.

Purpose

Observations can be used to provide an intensive period of assessment and support, although it may be perceived by the young person as not being needed, we hope you will generally view observations as a positive experience and recognise that observations are part of your care and treatment.

It is clearly not enough to simply observe young people. The process must be necessary, safe and supportive. Young people who need this level of help are going through a temporary period of increased need. Whatever the cause of this need, an individual has been assessed as requiring observations which will be carried out with compassion, understanding and will also become part of your identified treatment.

Risk Minimisation

The rational for the level of observations you may find yourself on are based on a variety of factors.

Central to it must be the risk assessment, which includes your reported risk and mental state at the time of assessment. Such as your history based on what has been reported, recorded thoughts and feelings that you have expressed, behaviour that could be worrying or information from third parties, such as what carers and clinicians report and the outcome of prior structured assessment reports. It is acknowledged that the process of risk assessment is ongoing and can be complex.

1. Making Enhanced Engagement and Observation Work

Some practical ways that observations can remain supportive between you the young person and the ward team are as follows:

Activities of Daily Living – staff may be available to help assist you to maintain self care, help write letters make telephone calls, etc., as appropriate.

Social Interaction – staff will try to engage in conversation about symptomology, but also general conversation topics. They will also respect a young person's need for silence.

Communication – staff will pay attention to non-verbal cues such as body language as well as verbal communications by the young person as these can tell us much about how you are feeling and your need for support.

Young people often have questions about their level of observations so we have tried to incorporate some information to help with understanding in the following paragraphs.

2. The following includes frequently asked questions relating to observations

How often will a member of staff check on me?

This will depend on the level of your assessed risk; you may be seen at irregular intervals in a pattern that can not be predicted. **All** young people are checked hourly, this is part of the organisation's fire safety checks. Other observations range from 30 minutes, 15 minutes, line of sight, or intrusive observations where a member of staff will be with you no more than an arms length away.

What impact will 15 minutes observations have on me?

Whilst you are on these levels of observations, staff will need to be with you if you leave the ward. This means that you will be escorted when you leave your ward, if you wish to go out on leave a member of staff would need to be with you. Although we appreciate this may feel restrictive, we also recognise that at this moment in time you are experiencing an acute phase of your illness which has led to a hospital admission. We wish to support you as much as possible at this point in your recovery, part of this support requires the nursing staff to observe you whilst you are not on the ward.

I am feeling better now how can I come off this level of observations?

A Clinical Team Leader, Deputy Ward Manager or the Ward Manager will explore with you how you feel about ... An assessment will be made and a decision reached as to whether your level of observations may be reduced. A Doctor may also be asked to take part in this assessment. **Will this level of observations carry on throughout the night?**

All observations will carry on throughout the 24 hour period unless care planned as not being necessary. For example, if you are at risk of leaving the unit you may not need to be checked in bed over night as the unit is locked, but would still need to be accompanied into the garden.

I do not want to be disturbed whilst asleep, especially at night

Staff will be as quiet as possible whilst doing checks. Where available they will try to conduct observations through the vision panel in your door, but if they need to check further by opening the door they will try to open and shut doors as quietly as possible. However, during these observations the member of staff has to check when a young person appears asleep that they are breathing and must monitor their physical health noting changes in body position, etc. Safety takes priority over privacy. If a young person appears asleep staff must check that this is the case they must not assume that young people are sleeping and/or that they should not be woken, they will also check that no other risks are present, this may on occasions require the nurse to look more closely and move bedding etc.

1:1 Observations

There are two levels of 1:1 - line of sight and intrusive

How will being on line of sight observations impact on me?

A member of staff will need to have clear sight of you at all times. You would need to be escorted off the ward, and Staff will need to accompany you in the toilet and bathing areas, however, as much as possible you dignity will be respected. Often young people are moved to a higher observation bedroom if available to support staff in maintaining this level of observation effectively. Staff would still need to be able to see you whilst you sleep, even at night and may require you to face them so that airways can be checked regularly.

What does intrusive observations mean?

This level of observations is similar to line of sight except that the member of staff would be no more than an arms length away at all times. Again where possible staff will look to move you to a higher observation bedroom, staff would need to see your face at all times and may require you to sleep with your hands visible to them too. Staff will need to accompany you in the toilet and bathing areas, however, as much as possible you dignity will be respected. Staff may feel it is safer to keep the room as free from personal belongings as possible as they could present a risk to you or others. You will be advised of which item(s) you can have access to and

those that you cannot.

Can I choose who I want to do my observation?

Please tell us if you would prefer a male or female to do your observations, we will try to work with your request where staffing allows. A member of staff should always knock on your door to inform you that they are entering, (this may not be done whilst you sleep so as not to wake you). Our aim is that only a member of staff of the same sex will observe you whilst you are using the toilet, bathing or washing facilities, or when undertaking other intimate activity. Maintaining your safety is our priority, therefore there may a very rare occasion when a safety issue is of a greater importance than privacy and for that reason, an intimate event may be observed no matter the sex of the staff member.

What if I still can not maintain my safety even on intrusive observations?

If the ward cannot help to keep you safe on this level of observations a more supportive environment would be considered. At Plym Bridge House this is called the Extra Care Area (ECA) or we may need to consider transferring you to a low secure unit. The closest young person's low secure unit is in Maidenhead, Berkshire. These types of units have a higher staff to patient ratio. Even if you are transferred to a low secure unit it does not mean that you will remain there for the duration of your hospital admission. You may return to another hospital as soon as your level of risk decreases.

How long will my intrusive or line of sight observations last?

Your observations would be reviewed daily by a consultant. He or she may state that the higher level of observations should be in place for a minimum amount of time, for example to support you over an anniversary date or following distressing news. The level of ongoing risk will guide the clinicians as to the length of time any observations need to remain in place.

Are observations an infringement of my Human Rights?

According to Article 8 of the Human Rights Act, everyone has a right to privacy, to family life, to his home and to his correspondence. However, it is not an absolute right. A person's Article 8 rights can be interfered with as long as such interference is (a) in accordance with the law and (b) necessary for the protection of health and morals or for the protection of rights and freedoms of others. Any interference also needs to be proportionate. Consideration needs to be given to issues of privacy, dignity and the preferences of the young person, including their ethnicity, gender, religion, sexuality and language. However safety issues are of greater importance than privacy. These considerations should be explained to you and recorded in your notes. If you have further concerns please speak to a nurse or ask to speak to an advocacy representative in the unit.

Why does the member of staff conducting my observations keep changing?

The member of staff undertaking engagement and observation within arms length

should do so for no longer than one hour followed by a break (from increased engagement and observation) of one hour. This is in recognition of the possible difficulty of maintaining concentration for more than this time.

How will I know what observations I am on?

If you are on intermittent observations this should be included in your care plan and clearly indicate:

◊ The reason for the intervention.
◊ The maximum time interval at which the engagement and observation must be carried out (e.g. 15 minutes).
◊ The task for the observer, e.g. Encourage young people to spend less time on their own; Check for signs of increased agitation etc.
◊ Consideration of environmental dangers and means to deal with them.
◊ What activities the young person can safely engage in and where, i.e. therapy groups, sports, work programmes etc.

Appendix M

Young Persons Guide to Seclusion at Plym Bridge House

1. What is it for?

Plym Bridge House Seclusion Area (is set up to give extra support to young people who are having problems with managing safe behaviours on the main unit. It may be used by young people who are at Plym Bridge informally, with their parent's consent or those young people subject to the Mental Health Act.

2. What is inside?

Plym Bridge House Seclusion Area (Named ECA) is off the main hallway and can have one young person, at any one time. There are two bedrooms, a separate bathroom, a lounge/dining area and an outside patio area.

3. Who decides that I can go into the Seclusion Area?

The decision about a young person going to the Seclusion Area will be with the staff team on duty usually the nurse in charge who will talk to the more senior nurses & the doctors. The staff team will review the young person's stay in the Seclusion Area many times during the day.

4. What Happens when I am in the Seclusion Area?

Any young person needing care in the Seclusion Area will be given 24 hour care and support until they are able to return to the main unit. This will be based on regular assessment of a young person's unsafe behaviour & distress.

The Seclusion Area is not a form of punishment and will never be used in that way.

The Seclusion Area will provide a young person with a short period of care & support to help with the management of their unsafe behaviour, when all the other things that we have tried have not worked.

Prior to going to the Seclusion Area all young people who are distressed or finding their unsafe behaviours a problem to manage, will be encouraged to use the calm down room.

Should a young person require a period of time in the Seclusion Area, the staff team will consider the young person being assessed under the Mental Health Act.

When a young person is admitted to the Seclusion Area during their stay

they will always be within eyesight of staff.

The length of time that a young person should be in the Seclusion Area at one time should not be longer than 72 hours (3 Days), after this the staff team will think about the young person being transferred to a unit that can provide a safer environment.

The care plan(s) that young people have stay the same, but an extra Seclusion Area care plan will be written which young people can have a copy. This will say what support the young person will receive when in the Seclusion Area

When appropriate the education, therapy & unit activities will carry on when the young person returns to the main unit. On rare occasions when a young person stays in the Seclusion Area longer than 1 day, the staff with the young person (if practical) will work out the young person's education & therapy needs.

Family contact will need to be thought about with the family & young person depending on the situation.

Young people won't be able to take many personal things with them to the Seclusion Area. However, we want young people to have enough of their own things to feel comfortable. Staff will be very thoughtful about any young people sleeping in the Seclusion Area and the things that will help them settle and sleep. The majority of the young person's stuff will remain in their bedroom on the main unit and this will be locked to keep it safe. We want young people to return to their bedroom on the unit as soon as is possible, and for young people to feel that their place within the unit is safe and their own.

5. How will I get back to the main unit?

Young peoples return to the main unit will be planned in by the staff team. The decision for a young person to begin going back to the main unit will be made once they have managed a period of safe behaviour within the Seclusion Area. The period of time will be decided by the nurse in charge and the doctors and will be led by the young persons needs. The young persons return to the main unit may be gradual if that best suits their needs.

When young people leave the Seclusion Area they will remain within eyesight of a dedicated member of staff for 24 hours. These observations will be reduced when the young person is assessed by the staff team to be ready to being checked by a member of staff every fifteen minutes for at least 24 hours.

Appendix N

Plym Bridge House (CAMHS Tier 4) Physical Intervention Protocol

Good decision making regarding physical intervention is essential when working with young people, therefore staff must up hold a sound ethos of care and respect for the young persons rights when physical intervention techniques are used without the young persons consent, staff must always ensure this is used a last resort and not the first line of intervention.

The practice of staff in such situations needs to be clearly understood by all staff, young people and their parents / carers. Parents / carers must be informed at the earliest opportunity when psychical intervention has been used with a young people and provided with a full update regularly for continued incidents. On admission parents / carers will be required to sign a consent form regarding that physical intervention may be used as a last resort if a young person becomes violent or aggressive.

Staff should be mindful of the fact that close physical proximity to young people who are highly agitated state can make matters worse and increase the level of risk.

Debriefing following any incident of physical intervention must occur as soon as reasonably possible and must include the young person, parents and staff. Staff must deploy good practice explain clearly to them why physical intervention was necessary. We will encourage the young person to express there thoughts and feelings re: the incident, in whatever creative way they would find helpful this could include verbal or written expression.

Where physical intervention techniques are used such practice should be consistent and considered and all actions taken must be fully recorded with in the young persons clinical records and ensure that it is clearly and comprehensively reported on an incident form in line with Livewell Southwest's Incident Reporting & Investigation Policy. Where an incident of highly restrictive physical intervention techniques are used, or a number of low level restrictive physical interventions take place we will be required to review the young persons mental health status with the unit consultant child and adolescent psychiatrist.

Following any incident where physical intervention has been used, staff must ensure that the young persons risk assessment is updated to reflect the young person's current level of risk. Should physical intervention be used frequently the young persons care plan must be updated to incorporate the young persons needs and include a staged process how and when to intervene and what preventative therapeutic interventions are helpful to the young person.

Should sedative medication be used to manage incidents of violence & aggression staff should always follow the Livewell Southwest Rapid Tranquillisation Policy for Under 18's and use the appropriate paperwork to monitor the young person's

physical health through physical observations.

All staff working within CAMHS will receive training in break away techniques, conflict resolution, basic life support and specific bespoke training in psychical intervention techniques appropriate for young people aged 12-18yrs.

When the safe environment of Plym Bridge house is challenged by violent or dangerous behaviour of a young person, staff need to achieve a prompt and safe resolution of the situation.

When physical intervention is used it must be justifiable, appropriate, reasonable and proportionate to the specific situation and applied for the minimum possible time. Staff must consider a range of strategies to ensure the situation is managed appropriately; this will include good use of therapeutic interventions, the environment and facilities i.e. supportive 1-1 time, use of the chill out room and in the last case scenario the Extra Care Area (ECA), please see ECA protocol.

Efforts must be made to ascertain the young persons trigger factors, early warning signs and history of aggressive or violent behaviour, additional vulnerabilities and the appropriate management of these.

All staff should seek to promote an atmosphere of calm consistency and order so that young people and staff feel secure.

All staff are expected to have an awareness of the needs of different cultures and to respond appropriately.

Any physical condition must be considered prior to any physical intervention being due to an increased risk of collapse or injury during physical intervention, staff must ensure it is clearly documented in the risk assessment and care plan, and communicated; this will include:

a) Age
b) Weight
c) History
d) Eating disorder
e) Substance misuse
c) Asthma
d) Heart disease
e) Learning Disability
f) Pregnancy
g) Exposure to CS spray / gas
h) Muscle and joint impairment
i) Problems with cardio pulmonary function

Appendix O

Plym Bridge House (CAMHS Tier 4)
Section 85 Children Act Notification Policy

Livewell Southwest

Section 85 Children Act Notifications

Version No 1.2

Notice to staff using a paper copy of this guidance

The policies and procedures page of LSW Intranet holds the most recent version of this document and staff must ensure that they are using the most recent guidance.

Author: **Designated Nurse Safeguarding Children**

Asset Number: **195**

Section 85 Children Act notifications

1 Introduction

1.1 When a child has been in hospital for a period of three consecutive months or is expected to be in hospital for such a period health organisations ('accommodating authority') are obliged to inform the Local Authority Children's Services ('responsible authority') of this fact under Section 85 of Children Act (1989). This is to enable the responsible authority to:-

- Take such steps as are reasonably practicable to enable them to determine whether the child's welfare is adequately safeguarded and promoted while he is accommodated by the accommodating authority;

  and

- Consider the extent to which (if at all) they should exercise any of their functions under the Children Act with respect to the child.

2 Purpose

2.1 The purpose of this policy is to ensure Livewell Southwest () meets its statutory responsibilities under Section 85 Children Act (1989).

3 Scope

3.1 This policy covers all children / young people who are in hospital for three consecutive months and set out the responsibilities of Livewell Southwest.

4 Duties

4.1 It is the responsibility of Ward Managers in wards which ordinarily accommodate children / young people to display notices in patient areas informing parents/carers of the obligation to inform Local Authority Childrens Services. (see **Appendix A** for example).

5 Definitions

5.1 A child is a person under the age of eighteen years at the point of notification to the responsible authority.

5.2 The responsible authority is the local authority within which the child was ordinarily resident immediately prior to admission.

5.3 The accountable Authority is the health organisation in which the child is an in patient.

6 Procedure

6.1 When a child has been accommodated by the Livewell Southwest for a period of three months, or when a plan for care is drawn up which will necessitate the child remaining in hospital for three months or more, the Ward Manager must ensure this information is forwarded to the Responsible Local Authority and copied to the Named Nurse for Child Protection. The information to be forwarded must include (see sample letter Appendix B).

- Childs name
- Childs date of birth
- Child's address immediately prior to admission (or that of mother immediately prior to delivery)
- Date of admission to hospital
- Ward/Department
- Name and contact details of parents/carers

The name of this practitioner making the notification must be recorded in the child's records.

A copy will be held in the child's medical records and given to the child's parents/carer. Where it appears to the accommodating authority that a child was not ordinarily resident within the area of any local authority, the local authority within whose area the accommodation is situated will be informed.

6.2 When a child is subsequently discharged the Ward Manager (or person delegated) must inform the Local Authority and Named Nurse Child Protection. (see sample letter Appendix C).

The information to be forwarded is

- Child's name
- Child's date of birth
- Address discharged to
- Date of admission and date of discharge
- Name and contact details of parents/carers

This information must also be forwarded should a child die.

7 Monitoring Compliance and Effectiveness

The Named Nurse and Ward Managers will monitor the compliance with this policy through supervision on a case by case basis.

Livewell Southwest

Appendix A

If your child is expected to be in hospital for 3 months or more the hospital is required to inform the child's Local Authority Children's Services.

The Local Authority Children's Services may then assess if additional facilities and support are needed to help you meet your child's needs.

Before any information is shared with the Local Authority they will inform you of their need to share.

The Hospital will tell the Local Authority Children's Services:

Your child's name
Date of birth
Child's address
Date of admission to hospital
Parent/Carer name and contact details
Date of discharge

If you have any concerns or require any further information please speak to the Ward Manager

Livewell Southwest

Appendix B

Address

[DATE]

Dear

Re: **Name:** **Date of Birth:**

Contact details Parents/Carers:

Unit/Ward:

Under Section 85 of Children Act 1989 I would like to inform you that the above child has been accommodated by this unit for a period of three months.

Childs name

Childs date of birth

Child's address immediately prior to admission

Date of admission to hospital

Ward/Department

Name and contact details of parents/carers

His/her parents/carers are aware of this notification.

Yours sincerely

WARD MANAGER
Copy: Named Nurse Child Protection

Livewell Southwest

Appendix C

Address

[DATE]

Dear Sirs,

Re: Name: Date of Birth:
Address:
Date of Admission:
Contact details Parents/Carers:
Unit:

Under Section 85 of Children Act 1989 I would like to inform you that the above child has been accommodated by this hospital for a period of [enter length of admission] and has now been discharged from this unit

Date of Discharge …………………….

His/her parents/carers are aware of this notification.

Yours sincerely

WARD MANAGER

Copy: Named Nurse Child Protection

Appendix P

Plym Bridge House (CAMHS Tier 4)
Seclusion Policy

Livewell Southwest

Plym Bridge House (CAMHS Tier 4) Seclusion Policy

Version No. 1.1

Notice to staff using a paper copy of this guidance

The policies and procedures page of LSW Intranet holds the most recent version of this document and staff must ensure that they are using the most recent guidance.

Author: **Unit Manager/ Modern Matron TIER 4 CAMHS**

Asset Number: **15**

Plym Bridge House (CAMHS Tier 4) Seclusion Policy

1. Introduction

1.1 Seclusion is the supervised confinement of a patient in a room, which may be locked, for the protection of others from significant harm. The procedure is not specifically regulated by statue but the Mental Health Act Code of Practice applies. Seclusion should be used as little as possible and for the shortest possible time. Seclusion should not be used as a punitive measure or to enforce good behaviour. Although it falls within the definition of medical treatment in the Mental Health Act (section 145), seclusion is not a treatment technique and should not feature as part of any treatment programme.

1.2 At Plym Bridge House (PBH) Seclusion will operate within PBH Extra Care Area (ECA) which aims to provide extra support/treatment programs of care to young people who are experiencing difficulties in managing appropriate or safe behaviours on the main unit.

1.3 Seclusion is a last resort when all reasonable steps have been taken to avoid its use – its sole aim is to contain severely disturbed behaviour, which is "likely to cause significant harm to others, irrespective of their legal status".

1.4 Seclusion should not be used if the "primary risk assessed is that the patient may take his or her life, or otherwise harm him or herself".

2. Environment

2.1 Plym Bridge House ECA is located off the main hallway area and can facilitate a young person, using this facility at any one time. There are bedrooms, separate bathroom, lounge/dining area and a secure outside patio area.

3. Purpose

3.1 Seclusion at Plym Bridge House within the ECA is an option for all young people residing on the main unit. The purpose of seclusion is to provide appropriate support or care in relation to extremes of unsafe or challenging behaviour within the main unit which pose a threat to the safety of other young people on the unit.

3.2 The policy was devised by Managers of PBH as part of Plymouth Community Health Care.

The Chief Executive is ultimately responsible for the content of policies and their implementation.

3.3 Directors are responsible for identifying, producing and implementing Livewell Southwest policies relevant to their area.

3.4 Assistant Directors will support and enable operational Clinical Leads and Managers to fulfil their responsibilities and ensure the effective implementation of this policy.

3.5 The matron / manager is responsible for monitoring and auditing the use of seclusion.

3.6 The Ward / Unit Manager is responsible for ensuring the policy is in place and all Staff adhere to it.

4. Assessment

4.1 Any young person requiring Seclusion will be provided with 24 hour care and support up until the time that they are able to return to the main ward. This will be based on a thorough assessment of levels of agitation, arousal, distress and risk to themselves or others. The use of Seclusion should always be used as a last resort and for the least amount of time possible, when all other strategies have been exhausted, such as skilled distraction and diffusion techniques. Staff must in all cases support any young person who is distressed or displaying any extremes of unsafe behaviours to use the calm down room before considering using Seclusion.

5. Procedure

5.1 The initial decision to seclude a patient will be made by the Nurse in charge of the ward, the unit manager, deputy or clinical team leader will be informed out of hours this will be the senior nurse on call for PBH. Staff involved in disturbed incidents who have been the subject of assault/abuse should not usually be involved in secluding the patient where possible. The nurse in charge directs the procedure and assumes responsibility for ensuring the procedure is followed. If there is a clear rationale for Police involvement this should be discussed with the senior person on duty or on call and recorded on the Seclusion Record (Appendix A).

5.2 If the police attend, to assist in seclusion of a patient, a Serious Incident Requiring Investigation form needs to be completed.

5.3 Review times as stipulated in this policy must be adhered to.

5.4 The nurse in charge will inform the patient of the rationale for the seclusion and make it clear what is expected of them.

5.5 Review times as stipulated in this policy must be adhered to.

5.6 The ward doctor or duty doctor should be informed of the decision to seclude, and should attend if clinically indicated. An entry must be made in the patient's health record and on the Seclusion Observation Record form, detailing the doctor's attendance.

5.7 The Senior nurse / Matron on duty (during working hours) should be informed. They will inform other staff such as the RC, Manager/ on call

senior nurse. Any new episode of seclusion will be notified to NHSE case managers at the earliest opportunity. Along with the notification there needs to be the reason for the seclusion episode and potential seclusion period.

If the service user is informal consideration should be given as to whether formal detention under the Mental Health Act is appropriate.

5.8 Informal Patients

When transferring any young person to the Extra Care Area who is an informal patient, i.e. not detained under the Mental Health Act, serious consideration should take place as to whether a Mental Health Act assessment is required in order to protect the young person's rights and so they are not detained illegally.

The Mental Health Act Code of Practice, paragraph 15.46 states: "Seclusion of an informal patient should be taken as an indication of the need to consider formal detention". Once a young person is in the ECA they would be placed on a 5(4) by a member of nursing team, and then contact the doctor for a 5(2) assessment Section 5 (2), this is a temporary hold of an informal or voluntary service user on a mental health ward in order for an assessment to be arranged under the Mental Health Act 1983.

The patient's valuables or any other belongings considered to be potentially harmful should be removed from the patient in accordance with Livewell Southwest Search Procedure. These should be recorded on the Seclusion Record (Appendix A).

When entering or exiting the Seclusion Room, control and restraint techniques must be planned and implemented as required.

A designated nurse must be in attendance at all times inside the Seclusion area (ECA). They must be relieved hourly. The aim of the observation, as well as maintaining the patient's safety, is to ascertain the patient's mental state and whether seclusion can be terminated.

The Seclusion Recording (Appendix A) must be completed immediately and an entry made in the health record describing the behaviour and mental state of the patient prior to seclusion and detailing what other interventions were made.

A written and signed entry to be made at least every 15 minutes by the observing nurse, on the Seclusion Observation Record (Appendix E). This should represent the observations made throughout the 15 minute period. This would require continual observations, however this may at times require the staff to be discreet.

A nursing review carried out by two nurses must take place every two hours and if possible this should be done by direct contact with the patient. This review is to be recorded in the health record. Attempts should be made to

carry out physical observations including pulse and blood pressure at these reviews. This should be documented on the Seclusion Record Nursing Review (Appendix B). (If it was not possible to carry out the physical observations the reasons why must be detailed on the form).

Care must be taken that all the patient's basic needs (hygiene, nutrition, etc.) are met as far as possible whilst they are in seclusion. Any intervention carried out should be recorded on the Seclusion Observation Record by the observing nurse.

Within four hours, a joint medical and nursing review must take place, involving direct contact with the patient, inside the room. Entries to be made in the health record and the review noted on the Record of Seclusion and the Joint Medical/Nursing review (Appendix3) completed. This should be following a risk assessment.

Names of the staff involved in the review are to be clearly written in the notes.

Thereafter, joint medical and nursing reviews must take place every four hours. Doctors and nurses involved in reviews should use their professional judgement to decide whether or not they need to consult with senior colleagues.

If, for any reason, joint medical and nurse assessments are delayed the reason for the delay must be documented in the patient's notes.

5.9 If the seclusion is during the night hours, and the patient falls asleep, the following may happen:

- The decision is made to keep the patient in seclusion, and two hourly reviews take place, indicating that the patient is asleep, this must be reviewed with the consultant the next day, as soon as patient awakes a further review must take place.

- The decision may be taken that the patient no longer requires seclusion, but rather than wake the patient they will be offered the opportunity to leave as they wake. A nurse must remain observing the patient until the patient wakes.

5.10 If seclusion continues for more than eight hours consecutively, or for more than twelve hours intermittently over a period of 48 hours, an independent review must take place with the RC or other doctor of suitable seniority, and the Ward Manager/Nurse in Charge of the ward. If there is no agreement on ensuing action, the matter should be referred to the Unit Manager / Matron.

5.11 The outcome of this review should be recorded on the Seclusion Record – 8 hour Review Form (Form 4).

5.12 Decision to terminate seclusion will be taken by the nurse in charge of the

ward in consultation with the designated ward doctor/RC The manager on duty for the hospital is to be informed, at an appropriate time i.e. within working hours. All data must be appropriately recorded and signed – i.e. Record of Seclusion form / health record.

5.13 If a patient needs to be secluded again after termination of the initial seclusion, a new Record of Seclusion form must be started.

5.14 Any incident of seclusion, the circumstances leading up to it and method of management should be discussed at the next meeting of the clinical team with patient present if possible.

5.15 The patient should be “debriefed” about the events and decision, which led to their seclusion. This should be recorded in the daily records.

5.16 Copies of the Seclusion documentation must be sent daily to the Unit Manager.

5.17 A monthly summary of all incidents of seclusion must be compiled by the Unit Manager. This information is required by the Care Quality Commission, and is also useful for internal auditing purposes.

5.18 When necessary safe physical intervention or medication may be used in accordance with Livewell Southwest policies. However, in addition to this, guidance may be sought from the Livewell Southwest’s physical intervention team with regards to distraction and diffusion techniques, if required, to further enhance safe management of the young person if in crisis. This should then be incorporated in the young person’s care plan.

6. Staffing

6.1 When a young person is secluded there will be a minimum of one qualified member of nursing staff in the ECA whenever it is occupied by a young person. The nursing management team will be responsible for staffing of the ECA in conjunction with the risk management plan and the care plan. This should at least be a minimum of two staff during waking/night hours, unless detailed in the care plan. This should be reviewed at each shift change and staff rotated, in order to facilitate breaks and avoid excessive pressure on staff if staff are feeling pressured or stressed through staffing the ECA they should discuss this with the nurse in charge or their line manager.

7. Integration Back Into the Main Unit

7.1 Integration can be planned in conjunction with any of the following: nursing team on duty, management team or wider MDT if required. The decision for a young person to begin integration back to the main unit will be made once the young person has maintained a period of safe behaviour within seclusion. The duration of this should be decided by the nurse in charge and will vary considerably depending on the young person involved, the length of time that they have spent in seclusion and their clinical presentation. These factors will need to be taken into consideration by the nurse in charge of the shift, with nursing management

team, unit consultant or ward doctors. Discussions must be held with the young person regarding their assurances and feelings that they are able to better manage themselves on the main unit. During office hours the nurse in charge can liaise with the unit consultant or their deputy or the modern matron or their deputy. Out of hours and at weekends the nurse in charge can liaise with the senior nurse on call and/or consultant on call. All decisions re the young person's transfer back to the main unit should be recorded in the young persons' notes, noting the reasons for decisions, discussions with the young person, discussions with other members of the MDT, timings, integration plans and any other relevant information.

7.2 Young people who are leaving seclusion will need to remain on a minimum 1:1 within eyesight observation for 24 hours following their time within the ECA and to then be stepped down to intermittent observations, for a further period of 24 hours.

7.3 It is essential that information regarding integration of a young person who has been secluded that extends to the next shift is presented at the handover.

7.4 The reintegration to the main ward can be a graded process when required, i.e. evaluated at each stage to maintain the young people's safety.

7.5 The Unit Manager / Matron will be responsible for monitoring the use of Seclusion. The completed Seclusion paperwork will be kept centrally within PBH Any incident occurring during or following the seclusion procedure will be reviewed with the relevant locality manager, the Responsible Clinician and the senior Unit Manager / Matron.
The use of seclusion will be monitored on a six monthly basis.

References and Key Sources Used

Care Standards Act 2000
National Minimum Standards Independent Health Care 2002
The Private and Voluntary Health Care (England) Regulations 2001
Children's Act 1989
Mental Health Act 1983.
RCPsych Quality network for In-Patient CAMHS Standards

Appendix A

Seclusion Record

Date:	

Name of Patient:	
Mental Health Status:	
NHS number:	
Address:	

Next of Kin:	
Contact Tel No:	

Time seclusion implemented:	
Police called: YES/NO record time	
Police Arrived: record time	
Police involvement: provide full details including any physical restraint.	
Rationale for requesting Police:	

Time seclusion stopped:		Date seclusion stopped:	

Brief description of events and rationale for seclusion / Patient response to seclusion: Please include any property that has been taken from the patient prior to placing into seclusion

Two hour review due:	
Signature of decision maker:	
Name: (PRINT)	
Designation:	

Copies to: Senior Nurse / Matron
Patients file
NHSE Case Manager

Appendix B

Seclusion Record Nursing Review (2 hourly)

Date:	

Name of Patient:	
NHS No:	
Mental Health Status:	

Time of Review:	

Appearance: (Pulse, Blood Pressure, Behaviour etc.)

Details of Review: (and reasons for decisions made)

Next Review due:	

Print name: Signature of Reviewing Staff: Designation:	1)
	2)

Appendix C

Seclusion Record Joint Medical / Nursing Review (4 hourly)

Date:	

Name of Patient:	
Hospital No / NHS No:	
Mental health Status	

Time of Review:	

Appearance: (Pulse, Blood Pressure, Behaviour etc.)

Details of Review: **(and reasons for decisions made)**

Print name: **Signature of Reviewing Staff:** **Designation:**	1)
	2)

Appendix D

Seclusion Record

Date:	

Name of Patient:	
Hospital No / NHS No:	
Mental Health Status:	

Time of Review:	

Details of Review and Care Plan:

Signature of Doctor: Print name / designation:	
Signature of Nurse: Print name / designation	
Signature of Manager: Print name / designation	

Appendix E

Seclusion Observation Record

Name:	
NHS No:	
MHA Status:	
Ethnicity:	

Date:	

Time seclusion started:	

An entry in these notes should be made every fifteen minutes, by the Nurse assigned to the observation duty.

Date	Time	Observations	Print Name Signature Designation