St Andrew's Healthcare Adolescent Services Northampton

Quality Report

Cliftonville House
Billing Road
Northampton
NN1 5DG
Tel: 01604616000
Website: www.stah.org/

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Overall summary

We did not rate this service.

We found:

- We found that not all patients in seclusion or segregation had care plans in place.
- Not all patients had signed the paper copy of their PBS plans. It was difficult to ascertain if they were involved with the writing of the plans held electronically. Staff had not recorded if patient had declined.
- Staff reported that they had not received formal training around PBS, although the psychologist took the lead and invited all staff to regular meetings to discuss implementation of these.
- From a sample of records looked at, we found that four out of 12 patients did not have a restraint care plan in place.

However:

- Staff we spoke with followed positive behavioural planning (PBS) and placed emphasis upon least restrictive practices. Patients had comprehensive PBS plans within the electronic records, as well as shorter versions, in paper form, held on the wards. This enabled staff to have easy access to plans. They were in easy read versions where appropriate.
- Staff were trained to use restraint as a last resort, with emphasis upon de-escalation and the prevention of aggression. Staff did use prone (face down) restraint, but this was for the shortest time possible. This was reflected in documentation seen.
- Data provided showed a downward trend in the use of restraint, including prone restraint.
- Staff recorded incidents of restraint accurately, in line with the provider's policy.
- Staff received mandatory training and most staff were up to date with this.
- Staff were kind and respectful during interactions observed, and tried to do the best for the patients.
- Staff involved carers of patients when it was appropriate. Two carers we spoke with confirmed this.

Summary of findings

- Patients had been able to contribute to ideas around the new building. This included choosing all new ward names.

Summary of findings

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Wards for people with learning disability or autism

Summary of this inspection

Background to St Andrew's Healthcare CAMHS

St Andrew's Healthcare Northampton has been registered with the CQC since 11 April 2011. The services have a registered manager and a controlled drug accountable officer. The registered locations at Northampton are adolescent services, men's services, women's services and acquired brain injury (neuropsychiatry) services.

Northampton is a large site consisting of more than ten buildings, more than 50 wards and has 659 beds.

St Andrew's Healthcare also has services in Nottinghamshire, Birmingham and Essex.

The locations at St Andrew's Healthcare Northampton have been inspected 19 times. The last inspection was in June 2016.

Patients receiving care and treatment at St Andrew's Healthcare follow care pathways. These are women's mental health, men's mental health, autistic spectrum disorder, adolescents, neuropsychiatry and learning disabilities pathways.

The following services were visited:

Child and adolescent mental health wards

Wards for people with learning disabilities or autism:

The adolescent services for patients with learning disabilities and autism provide inpatient accommodation for patients with learning disabilities under the age of 18 years. We inspected the following wards:

- Acorn ward (formerly Bayley) is a ten bed medium secure forensic service for boys with autistic spectrum conditions and / or learning disabilities.
- Bracken ward (formerly Heygate) is a ten bed medium secure forensic service for boys with autistic spectrum conditions and / or learning disabilities.
- Fern ward (formerly Fenwick) is a ten bed low secure service for girls with neurodisability and / or autistic spectrum conditions.
- Brook ward (formerly Church) is a ten bed low secure service for boys with neurodisability and / or autistic spectrum conditions.

The child and adolescent services moved into a new building in January 2017 called Fitzroy, the ward names had changed as part of this move.

St Andrew's healthcare offers low and medium secure specialist services for children and adolescents with mild / moderate learning disabilities, autistic spectrum disorder, behaviour that challenges and individuals who may have a mental health problem and offending history. They offer care and treatment to children and adolescents who may have a neuro-disability. There is a bespoke service for an individual within the grounds.

The adolescent service is able to offer education opportunities for young people through St Andrew's college. The college is Ofsted registered and rated as outstanding.

This inspection was a focused inspection looking at the use of restraint in learning disabilities services. We gave the provider a week's notice of our intention to carry out this inspection. We also inspected the learning disabilities and autism wards in men's services and adolescent services.

Our inspection team

Team leader: Margaret Henderson

The team that inspected the services comprised of two CQC inspectors, an assistant inspector, and a national professional advisor who is a consultant psychiatrist with learning disabilities experience.

Summary of this inspection

Why we carried out this inspection

We carried out this focused inspection following concerns raised by other organisations nationally about the use of restraint in learning disabilities services.

How we carried out this inspection

We carried out this inspection as a focused inspection looking specifically at the use of restraint in learning disabilities services. It was announced a short time before our inspection to enable the provider to give us up to date information.

Before the inspection visit, we reviewed information that we held about the location.

During the inspection visit, the inspection team:

- visited four wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 14 patients who were using the service
- interviewed the registered manager and managers for each of the wards
- spoke with 16 other staff members; including doctors, nurses, psychologists, social worker and healthcare assistants
- looked at 12 care and treatment records of patients
- observed a multidisciplinary meeting (formulation meeting)
- spoke with two carers of patients who use the service and
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with 14 patients. Eight out of the 14 patients said there was not enough staff, which stopped them doing what they wanted to.

Most patients told us staff were helpful and understanding.

Of the 14 patients, 11 told us staff had restrained them. Eight patients told us staff had explained why this had happened, and had spent some time with them after the restraint. Three patients said they had not spoken with staff about it.

Nine out of the 14 patients spoken with had spent time in seclusion. Of these, five told us they understood why. Four patients said they had not discussed with staff and did not really understand why they ended up in seclusion.

We spoke with two carers of people who use the service. One told us they were very pleased with the care and treatment offered, and felt staff had built a good rapport with their relative. They said they phoned the ward regularly and received appropriate updates from staff. No concerns were expressed.

Another carer said the staff at the hospital were good at keeping in touch and providing regular updates around care and treatment.

We reviewed the action plan from a carer's event held in June 2016. The main points were that carer's wanted more information and wanted to be involved more, St Andrew's had taken action to improve these.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found:

- We identified that four patients, out of a sample of 12 care records looked at, did not have a seclusion or long term segregation care plan in place.
- Staff and patients interviewed felt there was not enough staff to meet the needs of the patients. Patients said that they did not do what they wanted to do because there was not enough staff available.
- There was a psychiatrist on call throughout the night, and a second doctor worked up until midnight. These doctors covered the entire hospital. Doctors confirmed they found it difficult to attend to all seclusion reviews in a timely manner due to workload.
- Two out of the 12 records looked at had incomplete restraint care plans.
- Although the psychologist invited staff to formulation meetings to enhance staff knowledge on patients' PBS plans, staff interviewed told us they had not received specific training around PBS.

However:

- Staffing numbers met establishment levels. Bank and agency staff were being used regularly to cover enhanced observations. Where possible, staff familiar with the service was requested.
- There was emphasis upon positive behavioural support (PBS) plans. Each electronic record looked at contained an extensive PBS plan, although the extent of patient involvement was not always clear. Each patient had a shorter, PBS plan in paper form on the ward and easy read versions were available where appropriate.
- Staff were trained to use restraint as a last resort and this was reflected in documentation seen. Staff avoided using prone restraint, and if a patient ended up in this position, staff re-positioned at the earliest opportunity. Staff used prone restraint to administer injections, for the shortest time necessary. Training was provided for staff to use different sites for injection, which meant prone restraint was not needed.
- Data provided showed a downward trend in the use of restraint, including prone restraint.

Summary of this inspection

- Most staff had completed the management of actual and potential aggression (MAPA) or were scheduled to complete this.
- Staff received mandatory training. Compliance rates across the four wards inspected ranged from between 86% to 98%.
- Staff reported incidents of restraint in line with hospital policy. Ward managers reviewed incidents on their wards, and followed these up where necessary. Staff discussed incidents at weekly multidisciplinary meetings.

Are services caring?

We found:

- Staff interacted with patients in a caring and respectful manner, and demonstrated an understanding of individual need.
- Most patients told us staff were helpful and caring.
- Two carers we spoke with were happy with the care and treatment provided. There was appropriate family involvement where possible.
- Advocacy services were available and patients knew how to access these.
- Patients had been involved in discussions around the development of the new building, for example ward names, colour schemes and artwork.

However,

- Out of the 34 copies of the paper PBS plans held on each ward, only 14 had been signed by the patients.

Detailed findings from this inspection

Child and adolescent mental health wards

Safe	
Caring	

Are child and adolescent mental health wards safe?

Safe and clean environment

- Resuscitation equipment was available, with six emergency bags located within the building. If there was a medical emergency staff could access this equipment quickly.
- The unit had designated seclusion facilities. Each seclusion area was of a suitable standard and met the Mental Health Act 1983 code of practice. Staff had clear visibility into each room to ensure patients were closely monitored. Rooms were adequately lit and had temperature controls. Toilet facilities were available which patients could access when required. Patients could see a clock and so were orientated to the time.
- All staff and visitors had alarms so that they could call for assistance if required.

Safe staffing

- Each ward had set staffing which met establishment levels. Extra staff were used to cover increased observation levels for patients. The provider had their own bank staff which they used to cover any staffing needs in the first instance. If bank staff could not be sourced then the required shifts were filled by agency staff. Where possible the wards requested bank and agency staff that were familiar with the service. Of the patients we spoke with, 57% told us that they felt that staffing was an issue in terms of meeting their needs. Of the staff interviewed, 63% told us they felt staffing levels were a concern, and affected time spent with patients. Two staff members we spoke with said doctors had been asked to attend to patient's personal care, and conduct enhanced patient observations on occasions due to shortages with staffing.
- Data provided showed that the four wards were requesting high levels of additional staff. Over a three month period, between November 2016 and January 2017, the four wards used a total of 3,849 shifts covered by bank or agency staff. Of these, 3,545 (92%) were covered with bank staff. Agency staff covered the remaining 304 shifts.
- Staff were trained in the prevention and management of aggression and violence (PMAV). The provider was converting its PMAV training to the 'management of actual and potential aggression' (MAPA). Most staff within the adolescent pathway had completed this training. Staff we spoke with who had not, had been scheduled to attend upcoming courses. Staff were able to describe the differences in the training, with MAPA having a greater emphasis upon de-escalation. MAPA is a nationally recognised training.
- Each ward had adequate medical cover throughout the day so that a doctor could attend the ward in an emergency. At night, there was one psychiatrist on duty overnight, with a second who worked until midnight. These doctors covered the whole hospital. If there were several patients in seclusion within the adolescent services, the doctor found it difficult to attend reviews in a timely manner.
- Staff received mandatory training, with staff over the four wards being between 86% and 98% compliant. Staff interviewed told us they had not received any specific training around PBS. However, five staff told us the psychologists lead on PBS, and they attended formulation meetings where a particular patient was identified and discussed. The patient's behaviours, possible reasons for the behaviours and interventions that could be effective for the patient were discussed. The staff who attended the meeting then relayed this information to other staff, and updated care plans.

Assessing and managing risk to patients and staff

- Staff we spoke with were familiar with positive behaviour support planning (PBS) and least restrictive practice. Across the service, 70 staff had been trained in PBS since November 2016 and a further 70 planned before the end of 2017. All patients had an electronic comprehensive PBS plan, which the multidisciplinary team had put together. However, there was minimal evidence that patients had contributed with the writing

of these. The plans looked at positive behaviours and behaviours to be discouraged. This was in line with the "reinforce appropriate, implode disruptive" (RAID) approach. RAID training is a three day course which aims to promote proactive management of risk behaviours. Staff would need to have basic knowledge around the RAID principles in order to fully understand PBS. Training around the RAID approach was being rolled out to staff across the service. However, statistics around which staff had completed within the adolescent service were not available at the time of inspection, 35% had completed across the LD service. PBS plans were available in paper form on each ward. These were more personalised and in easy read versions for patients when needed. This was useful for bank and agency staff that was unfamiliar with the patients.

- Staff told us the use of restraint was a last resort and were able to describe individualised de-escalation strategies they would use initially, with each patient. Data provided showed a downward trend overall in the use of restraint.
- Between the 1 January 2016 and 26 January 2017 there were 905 restraints in this service across the four wards. St Andrews healthcare recorded any hands on contact with patients as restraint. On Acorn ward the total was 82, of which 43 (52%) involved prone restraint. On Bracken ward, there were 134 restraints, with 44 (33%) prone restraints. Fern ward reported 320 restraints, with 84 (26%) in prone position. Of the four wards, Brook ward had the most restraints at 369, 59% of all restraints involved one patient on this ward. Of these, 41 (11%) resulted in the prone position. Staff avoided using prone restraint where possible due to the known associated risks. If a patient did end up in a prone position, staff would turn the patient over or into a different position at the earliest opportunity. Documentation reflected this. Staff took into account the patients preference about restraint if this had been discussed.
- There had been a number of reported staff injuries across the four wards between 1 January 2016 and 26 January 2017. These were because of either physical aggression from patients, or an injury sustained during restraint. On Fern ward 33 staff had been injured through patient aggression, and 12 during a restraint. On Brook ward 21 staff were injured due to patient aggression, and 12 during restraint. On Acorn ward, eight staff were injured through patient aggression, and four during restraint. On Bracken ward seven staff were injured through aggression, and four during restraint. Staff we spoke with told us they were supported by the ward manager and the modern matron if injured at work.
- During the same time period there were a total of 281 incidents of seclusion reported across the four wards. Bracken had the highest number recorded as 95; Fern had 77; Brook had 74 and Acorn reported 35.
- We looked at 12 care records, and saw restraint care plans in ten of these. However, two out of the ten were incomplete, with minimal information.
- We found four out of the 12 records did not have a seclusion or long term segregation management plan in place for patients who were, or who had been managed in seclusion / segregation.
- St Andrew's were carrying out a pilot to introduce "safewards" within the organisation. Safewards is a model of care which focuses upon reducing the use of restrictive interventions. Fern ward had introduced some of the interventions at the time of inspection.
- Policies have been updated to reflect latest national guidance and the Mental Health Act code of practice.

Track record on safety

- There had been no serious incidents reported at the time of inspection. We looked at eight incidents related to restraint. The incident forms captured the appropriate information and the ward managers had reviewed these, taking actions as necessary.

Reporting incidents and learning from when things go wrong

- Recordings of restraint were detailed. Staff entered details in the day to day progress notes. Each episode of restraint was reported as an incident electronically. The ward managers reviewed each incident. The incident form included the length of time of restraint, and what positions / holds staff used throughout. This enabled the service to capture the length of any restraint, including prone restraints. Staff discussed restraints and seclusions during the weekly multidisciplinary meetings. The ward managers followed up any incidents where necessary. Closed circuit television could be reviewed by senior staff to examine individual incidents that required further investigation.

Child and adolescent mental health wards

Are child and adolescent mental health wards caring?

Kindness, dignity, respect and support

- Staff interactions with patients were caring and respectful. Staff had an understanding of individual patient need.
- Patients reported they found staff helpful and supportive.
- Two relatives of patients spoke positively about the interactions staff had with their relatives.

The involvement of people in the care they receive

- Staff told us patients were involved in their care planning, unless they declined. We looked at 34 available paper copies of the PBS plans across the wards. Out of the 34, only 14 had been signed by the patients. Staff did not record if patient had declined.
- Parents and carers were involved in their relative's care where possible. They were invited to care programme approach (CPA) meetings. Patients were able to keep in contact via telephone, and with video technology. This was particularly helpful if relatives or carers lived some distance away.
- Patients had access to advocacy services. They could self-refer, or staff assisted when required.
- Patients felt able to give feedback to staff on the ward, or to the modern matron. Patients in the service could also access an online feedback webpage.
- Patients had been involved with the naming of the wards within the building and had given input about décor and artwork.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all patients who are being cared for in seclusion or long-term segregation have appropriate care plans in place.

Action the provider SHOULD take to improve

- The provider should ensure that all patients have restraint care plans in place.
- The provider should ensure that there is evidence of patients being involved in their PBS planning or record a reason they are not.
- The provider should ensure that all staff receive appropriate training in PBS planning.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: • There was not a seclusion or long-term care plan in place for four patients who had been managed in seclusion or segregation. This was a breach of regulation 12 (2) (a)