Southern Health NHS Foundation Trust

Child and adolescent mental health wards

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Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Summary of findings

Child and adolescent mental health wards

Good ➔➔

Summary of this service

We carried out a focused inspection of Austen House, a child and adolescent mental health unit at Southern Health NHS Foundation Trust.

The trust provides child and adolescent mental health wards in three locations: Bluebird house, Leigh house and Austen house. Austen house is a standalone unit with one ward set within its own grounds, close to the Tatchbury Mount site.

The wards are registered to provide the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983.
- Treatment of disease, disorder or injury.
- Diagnostic and screening procedures.

We visited Austen house following concerns raised from a Mental Health Act remote review of the ward. Young people had told the reviewer that there was not enough staff and this was impacted on their access to education, therapy, activities and that they had to wait a long time before being able to access the garden and mobile phones to call relatives. There were also concerns that due to the high number of incidents and young people on high level of observations that there were not enough staff to ensure young people received adequate support in a timely manner. At the time of the inspection two young people required nasogastric feeding. This is a method of feeding via a tube from your nose to your stomach. There were concerns that not all staff had been trained to complete this procedure.

As we visited only one ward in this focused inspection, the rating from the previous inspection still applies and this inspection will not include a rating.

We conducted an unannounced focused inspection looking at specific areas of the following key question:

- Is it safe?

During this inspection, the inspection team:

- Visited Austen house, looked at the environment and observed care
- spoke with the ward manager
- spoke with five staff including three nurses, one student nurse and two healthcare assistants remotely
- spoke with six young people over the phone as part of the Mental Health Act remote review
- spoke with six carers over the phone as part of the Mental Health Act remote review
- looked at five care and treatment records of young people
- reviewed incident reports
- looked at the previous three months of staff rotas, staff induction files and training matrix and other documents relating to the running of the wards.

Summary of findings

Is the service safe?

This was a focused inspection, so we did not rate this key question.

We found that:

- The service had enough nursing and medical staff, who knew the young people and received basic training to keep young people safe from avoidable harm.
- Staff assessed and managed risks to young people and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The service had a robust programme for reducing incidents of restraint which was starting to have a positive effect and ward staff participated in the provider's restrictive interventions reduction programme.
- The wards had a good track record on safety. The service managed young person safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave young people honest information and suitable support.

However:

- We noted a high number of restraints taking place although these were reducing.

Detailed findings from this inspection

Is the service safe?

Safe Staffing

The service had enough nursing and support staff to keep young people safe. The staffing level had been set at 10 members of staff on a long day, two on twilight and eight at night, but this had been increased by two staff on both night and day shifts over the last six months due to acuity of the young people. Managers had conducted an acuity and dependency test to ensure that they got the staffing levels right. The early results had shown that they would need the additional two members of staff on each shift permanently. Managers planned each shift according to the skills of the nurses and the requirements of the ward, for example, if they required extra escorts for young person's leave. There had been an additional member of staff employed to help do jobs to free up nursing time, for example, a member of staff had been employed to support access to computers and improve access to mobile phones.

The service had put adverts out to fill vacancies for its registered nursing positions. There were two whole time equivalent (WTE) band six nurse vacancies, 1.9 WTE band five nurse vacancies and 6.3 WTE band two vacancies. However, there were two band 4 aspirant nurses being recruited into the band five posts and there was an over recruitment of band three vacancies by 5.4 WTE to help cover the vacancies at band two.

A review of the previous three months of staffing rotas found that shifts were rarely under establishment. On the occasions that a shift was under establishment, we saw evidence that staff from other wards had come over to support the shift. The ward managers had a daily meeting to check staffing levels for the upcoming shifts. This meeting checked the planned number of staff against the actual number booked in. It also accounted for the number of young people on observations, for example, that may require extra staff. There were also daily meetings taking place across each ward during the coronavirus pandemic and these meetings were used to share staff across Austen and Bluebird house if required. The ward manager identified in the ward diary which nurses on shift were trained to complete the nasogastric feed and which nurses had been fit tested. All staff performing a procedure of this nature must be fit tested to ensure their personal protective equipment (PPE) fits adequately to prevent the risk of spreading infection.

Managers used bank and agency staff to fill in gaps in shifts. We found that there was an agreed pool of recognised and reliable staff from the hospital bank. Agency nurses had been block booked when necessary and there was a plan for recruiting five support workers to help the recent increase to 12 staff on each shift.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. We reviewed the local inductions for bank and agency staff and found them completed to an acceptable level. The nurse in charge ensured that all bank and agency staff were aware of each young person's likes, preferences and de-escalation techniques before starting their shift.

Mandatory training

Managers checked staff training monthly to ensure they were up to date. We saw that all staff had completed restraint training, and none were due for a refresher. The ward manager had been training nursing staff to complete nasogastric feeding, a method of feeding via a tube connected to your nose to your stomach. Staff had their competency assessed three times before completing the procedure unsupervised. At the time of the inspection 13 out of 18 staff had been trained.

Assessing and managing risk to young people and staff

Assessment of young person risk

Staff completed risk assessments for each young person on admission, using a recognised tool, and reviewed this regularly, including after any incident. We reviewed five sets of young person records and found that risk assessments were comprehensive and up to date. Young people, in conjunction with staff, completed a daily risk assessment called

Detailed findings from this inspection

Keeping Myself and Others Safe. This was a dynamic assessment that reviewed risks daily and care was adjusted accordingly, for example whether observations needed to be increased due to the young person's mental state or a young person's access to a certain area of the ward needed to be restricted. There was an additional multidisciplinary team risk assessment reviewed regularly and held more detailed risk information.

Management of young person risk

Staff knew about any risks to each young person and acted to prevent or reduce risks. Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained young people only when these failed and when necessary to keep the young person or others safe. However, we noted that there were a high number of restraints. There had been 688 restraints on 11 different young people in the time period March to July 2020. 676 of these were as a result of risk of self-harm. There was a downward trend of the use of restraint from May to July. Staff tried to avoid using prone and supine restraint where possible, but we heard sometimes it was unavoidable. The service had a robust programme for reducing incidents of restraint which was starting to have a positive effect and ward staff participated in the provider's restrictive interventions reduction programme.

Staff worked well together when managing incidents and allowed the member of staff who knew the young person the best to attempt to de-escalate the situation before intervening. Staff knew the young people well and were able to anticipate if a young person's risks were increasing. During the inspection we saw how a member of staff distracted a young person to avoid an incident from possibly occurring.

Staff could observe young people in all areas. There were two staff at any one time observing young people in the ward area and we observed staff engaging with young people throughout the inspection. The team increased observations according to risk, for example 1:1 observation or higher.

When a young person was placed in seclusion, staff kept clear records and followed best practice guidelines. There was a concern raised prior to inspection about a young person not being allowed out of de-escalation, however we found that seclusion policy was followed according to the Mental Health Act Code of Practice. Staff audited seclusion records to ensure that they followed best practice.

Young people had access to leave from the hospital depending on their level of risk. This was reviewed by the consultant psychiatrist. We reviewed the leave documentation for eight young people and found that young people had leave from the hospital up to seven times a week. Where a young person had gone a significant amount of time without leave, there was a clear rationale for why, typically due to a young person's risk levels increasing. Leave was rarely cancelled due to staffing shortages.

Reporting incidents and learning from when things go wrong

Staff reported incidents that occurred on the ward and there was de-brief available for both staff and young people. Staff knew which incidents required reporting and received feedback via email after their reports had been reviewed by a manager. Managers demonstrated how they supported staff and young people and showed how they had improved care for people following incidents. Learning from one incident related to re-feeding syndrome had triggered a review, and there were plans in place to provide extra training on staff induction as a result. Additionally, a learning from incidents review had seen a drop in restraints as a result of the extra support and learning for staff. For example, experienced staff showing newer staff how to deal with self-harm more effectively. Staff also attended a lessons learnt meeting to discuss how an incident could be improved and to share good practice.

Areas for improvement

Action the trust SHOULD take to improve:

Detailed findings from this inspection

- The service should continue with their approach to reducing the high levels of physical restraints.

Our inspection team

Our inspection team consisted of a head of hospital inspection, two inspectors, and one specialist advisor who was a nurse with experience of child and adolescent mental health wards.