Dorset Healthcare University NHS Foundation Trust

Pebble Lodge

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RDYFX	49 Alumhurst Road	Pebble Lodge	BH4 8EP

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

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

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

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards

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

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

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

Summary of findings

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Summary of findings

Overall summary

We undertook a focused inspection of Pebble Lodge following recent incidents related to the safe domain. One sadly included a fatality using a fixed ligature point.

During this inspection we found:

- Staff were knowledgeable around the identification and management of the risks of the young people and how they were managed and mitigated where possible.
- Young people's risk assessments were thorough and up to date, with evidence of the young person's input. Staff completed daily environment checks to assess risks in the environment, and they had a ligature risk management plan detailing the risks.
- Staffing levels were good, with staff stating they rarely felt short staffed. Whenever shifts were unfilled, the service used bank staff to cover these shifts and ensured the staff knew the ward and how it ran. Staff demonstrated awareness of how to raise a safeguarding alert.
- Restraint levels had fallen significantly between 1 January 2018 and 31 December 2018, in comparison to the last 12 months, from 123 to 47. Staff stated that restraint was used as a last resort.
- The environment was clean and well maintained, there was a well looked after clinic room. There was a low stimulus room to help young people with their mood.

However:

- The service had a number of fixed ligature points, such as en-suite doors, ceiling mounted fire alarms and radiator covers. Although the trust had identified and managed ligature risks well, and had ordered collapsible doors to replace the high-risk doors, they did not have a clear timeline to complete the intended work.

Summary of findings

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

Are services safe?

Safe summary:

During the inspection we found:

- The service completed comprehensive ligature risk assessments, with actions to mitigate the risks such as clinical observations.
- The trust had ordered collapsible doors to replace the high-risk doors in the service.
- Staff completed security checks of the care environment, including the garden area, to assess the risks of the environment.
- The service completed a risk assessment specific to the access to the pitched roof, following on from the health and safety investigation.
- Staff demonstrated good knowledge of the young people's risk and their management plans. Staff completed detailed risk assessments with the young people, and updated them after any changes in presentation, for example after an incident.
- Staff received regular reflective practice sessions. Staff and young people received debriefs following incidents.
- Staffing levels were rarely short, and when they were the service used bank staff who were familiar with the ward.
- The ward and clinic room were clean and well kept, with the clinic room and equipment checked daily.
- Staff demonstrated that they were aware of how to identify abuse and that they knew how to raise a safeguarding alert.
- The service had a low stimulus room to help the young people regulate their mood, with items such as weighted blankets.

However:

- There were a number of ligature risks identified in this service. Over the last three months, the service had had four fixed point ligature incidents, three relating to one young person and one sadly resulting in the death of a young person.

Are services effective?

- Since our inspection in November 2017 we have received no information that would make us re-inspect this key question.

Are services caring?

- Since our inspection in November 2017 we have received no information that would make us re-inspect this key question.

Summary of findings

Are services responsive to people's needs? • Since our inspection in November 2017 we have received no information that would make us re-inspect this key question.	
Are services well-led? • Since our inspection in November 2017 we have received no information that would make us re-inspect this key question.	

Summary of findings

Information about the service

Pebble Lodge is an inpatient mental health ward (Tier 4) for children and young people, provided by Dorset Healthcare University NHS Foundation Trust. It is located at Alumhurst Road in Bournemouth, a location which also includes inpatient mental health services for adults and community mental health services for adults and children and young people.

Pebble Lodge has ten beds, is mixed-sex and treats young people aged between 12 and 18 years. It provides 24-hour specialist psychiatrist care and treatment for those with emotional or mental health difficulties. Young people can be admitted informally or detained under the Mental Health Act (MHA) 1983. Pebble Lodge has an on-site school, the Quay school, that is registered with Ofsted (Office for standards in education, children's services and skills) and rated outstanding at its most recent Ofsted inspection in March 2015.

Pebble Lodge was previously inspected in November 2017. The service was rated as outstanding overall.

Our inspection team

The team that inspected this service comprised of one CQC inspection manager, one CQC inspector and one CQC assistant inspector.

Why we carried out this inspection

We carried out a focused inspection following notification of two serious incidents, one of a fixed point ligature sadly resulting in the death of a young person, and one of a fall from the roof at Pebble Lodge.

How we carried out this inspection

As this was an unannounced, focused inspection to follow up specific areas of concern we did not consider all five key questions that we usually ask.

Instead we concentrated on the area of concern and inspected specific aspects of the safe domain.

During the inspection we:

- visited Pebble Lodge,
- spoke with the ward manager,
- completed a tour of the ward and clinic room,
- spoke with eight members of staff, including the consultant psychiatrist, occupational therapist and members of the nursing team,
- reviewed care records for five young people and six medication records,
- reviewed a range of incidents on the hospital's electronic system and
- looked at a range of policies, procedures and other documents relating to the running of the hospital.

What people who use the provider's services say

We did not speak to any young people during the focused inspection.

Summary of findings

Areas for improvement

Action the provider SHOULD take to improve
We found areas for improvement in this service.

Action the provider SHOULD take to improve

- The provider should ensure that anti-ligature work continues with a time limited plan.

Dorset Healthcare University NHS Foundation Trust

Pebble Lodge

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Pebble Lodge	RDYFX

Mental Health Act responsibilities

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

Are services safe?

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

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

Our findings

Safe and clean environment

Safety of the ward layout

There were a number of ligature risks identified in the service. A ligature point is anything which could be used to attach a cord, rope or other material for hanging or strangulation. The service undertook a robust ligature risk assessment of the ward environment, which was reviewed annually at a minimum. Ligature points were graded according to risk, for example, red being the highest risk. The ligature risk assessment described the points identified, alongside photographic evidence of these points, and detailed the actions put in place to mitigate these risks. For example, clinical assessments to identify those at risk of ligaturing and increased observations. The risk assessment was comprehensive, informative and described all of the identified ligature risks such as the fire alarms and radiators. The trust had ordered collapsible doors to replace the high-risk doors.

However, there was no clear timeframe or action plan around possible removal of the other ligature risks, for example the fire alarms or radiators.

Staff completed security checks of the care environment three times a day. For example, checking the windows and garden area against a checklist to help them assess the risks of the environment. Following a fall from the roof at the service, there was a separate health and safety investigation completed to assess the risk of the roof of the building. The service completed a risk assessment specific to the access to the pitched roof in response to the investigation, which detailed further actions that the provider needs to take.

The ward layout allowed staff to observe most parts of the ward. The ward had some blind spots. However, these were mitigated by staff observation. There was staff presence in ward areas with a staff member allocated to observations at all times.

All staff had access to personal alarms (PIT) and were allocated one at the beginning of their shift. Staff could use alarms in an emergency or to request assistance. Staff from other wards on site could also respond to the ward if they needed extra assistance. There were call buttons in the ward areas and in young people's bedrooms.

Maintenance, cleanliness and infection control

The ward was bright, clean and welcoming, with well-maintained furnishings. The ward was cleaned regularly by contracted cleaners. On the day of the inspection, some of the bedrooms were being redecorated.

Seclusion room

Pebble Lodge did not have a seclusion room. However, it had a low stimulus room for the young people which had equipment such as weighted blankets to help with the regulation of mood. Young people that used this room were monitored by staff through observations and CCTV, if appropriate.

Clinic room and equipment

The clinic room was fully equipped with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff completed daily checks of the clinic room and equipment. The clinic was well organised and very clean. Ligature cutters were easily accessible to staff. Staff demonstrated good knowledge on how to use them.

Safe staffing

Nursing Staff

There were always five staff on shift during the day and four at night. There was also one twilight shift from 11am to midnight. The day shift was made up of two or three registered nurses and the rest support workers. The nightshift had one registered nurse and three support workers. There was always a qualified nurse on the ward.

At the time of inspection, there were two vacancies for band 3 support workers and two registered nurses. They were recruiting to these posts.

The ward manager could adjust the staffing levels daily, for example if more than one young person was on eyesight observations. Following the recent incident, the managers brought in extra bank staff to cover sickness and to ensure staff could attend the debriefs and/or counselling sessions.

Are services safe?

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

Staff told us that they were rarely short staffed, and when they were they used bank staff who were familiar with the ward. Agency staff were not used. The ward manager would also provide additional help when necessary.

Staff felt that staffing levels were good, and that they never felt understaffed or un-supported, despite the current vacancies. Members of the team stated that despite the challenges, the team had come through an unsettled period last year and felt robust.

Staff received assistance from other units on site if necessary during incidents.

Staff felt that it was very rare that activities or leave were cancelled as they tried to prioritise facilitating trips out.

Staff received training in using restraint techniques. There were enough staff on duty if restraint was required but staff stated this was used as a last resort.

Medical staff

Medical cover for the ward ensured that young people had access to a doctor throughout the day and night. Pebble lodge had two consultant psychiatrists, one specialist registrar and one junior doctor. A doctor was always available, with the doctor within the community CAMHS team being accessible during the day if necessary. There was also an on-call rota for out of hours.

Mandatory Training

As of 29 January 2019, 88% of staff had attended mandatory training. The trust had set a target that 95% of staff should have completed this; plans were in place to ensure this target was met.

Assessing and managing risk to patients and staff

Assessment of patient risk

Staff undertook a comprehensive risk assessment of each patient on admission to the unit. This was updated following the weekly ward round or if anything changed, for example following an incident.

Staff stated that risks of young people were assessed multiple times a day, for example, when discussing the access to leave. Staff held handovers every day where risks were discussed, as well as any changes to observations or presentation.

We reviewed five sets of care records. We found that four risk assessments were completed to a high level with a timeline of incidents. Records were comprehensive and timely reviews were completed following changes in treatment or after an incident. Records also detailed the plan to manage risk behaviours as well as any changes made. For example, one record noted an increase in observations following a request from a young person for this support. The other set of records was for a young person admitted on the day of the inspection. These contained two risk assessments providing a brief description of current self-harm risks. Staff recorded risk assessments in the electronic care records system.

Staff at Pebble Lodge completed an audit on care records every two weeks to ensure that things such as risk assessments reflected any changes in presentation, young people had a risk rating and that any action plans were present.

Management of patient risk

Staff displayed excellent insight and knowledge of the risks and needs of the individual young people. Staff could describe specific risks and how they have worked with the young people to manage these. For example, for one young person having a lot of staff surrounding them when distressed could escalate the situation. The staff recognised that limiting it to two staff and using de-escalation techniques such as talking or music was more helpful to this young person.

Staffed used observations to monitor the risk for each young person and to engage them in care and treatment. Staff said they could increase observations for a young person if they had concerns, without it being discussed within the wider multidisciplinary team. All staff we spoke to spoke confidently about voicing concerns about a young person, and felt supported and listened to when they had. Staff were knowledgeable about the role of observation in keeping the young person safe. For example, some young people were on fluctuating observation, meaning they could be on eyesight observations in their rooms but not on the ward areas.

The ward had CCTV they could use to observe the ward and garden area.

The staff team had weekly reflective practice meetings that focused on helping staff understand the young people to support their management of risks.

Are services safe?

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

The staff team used a risk incident matrix to help assess and decide the most appropriate way of dealing with the risks. For example, depending on rating, the team could arrange a medical review or a referral to a psychiatric intensive care unit (PICU) if appropriate.

The ward had a locked door policy although staff said that informal young people could leave at will if they asked nursing staff. There was a sign informing young people of their rights to leave the ward. The ward used different coloured disks on doors to indicate where young people could go unaccompanied on the ward. These were green for unaccompanied, amber for staff presence and red for no access to young people.

Staff only searched young people after leave if there was a suspicion that they had brought something back that could be used to harm themselves or someone else. If they had this suspicion and a young person refused to be searched they would be placed on one to one observations.

The ward had a list of banned items that were not allowed on the ward. This ensured that young people were always protected from certain items such as lighters, tobacco, drugs and plastic bags.

Use of restrictive interventions

This core service had 47 incidents of restraint (on eight different service users) and no incidents of seclusion between 1 January 2018 and 31 December 2018. This had reduced significantly compared to the previous 12 months restraint total which was 123. In addition, incidents resulting in prone restraint had fallen from 35 to four in the same time period. The ward manager stated that prone restraint had only been used if medicines had been administered. The use of rapid tranquilisation had decreased slightly, from 13 to ten in the last 12 months.

Staff felt that they rarely used restraint, and when they did it would usually mean the young person needed a psychiatric intensive care bed (PICU). Restraint was only used after de-escalation techniques had failed.

Safeguarding

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or adult at risk from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Staff demonstrated that they were aware of how to identify abuse and that they knew how to raise a safeguarding alert. All staff working on the ward were put forward for safeguarding level three training, and 94% of staff had completed this.

Staff received supervision around safeguarding if there was an alert raised. Two nurses on the ward were the lead for safeguarding and were the link with the safeguarding team within the trust. Staff could use a help line to discuss potential safeguarding alerts. An action plan was generated when this was used. This ensured that staff were supported and able to identify abuse and report it effectively in order to protect the young people on the ward.

Staff access to essential information

All relevant information about the young people was stored and accessed via the wards electronic record system. Young people also had access to things such as their care plans, which were created with the young people and reflected things that they liked and wanted from their care.

Medicines management

Staff followed good practice in medicines management. The pharmacist visited the unit weekly and they also attended ward round. The pharmacist was easily accessible if the service had any questions regarding medicines. The doctors based at Pebble Lodge would usually see the young people at least weekly outside of ward round time to discuss any issues regarding medicines.

As part of the initial assessment, medicines were discussed and reviewed with the young people. Young people were given information regarding any medicines they were on. Young people had weekly physical health checks.

Medicines were stock checked regularly, staff ordered more medicines when needed by contacting the pharmacy department. Medicine cabinets were tidy and well stocked. Staff checked controlled drugs regularly.

Track record on safety

There were two serious incidents reported by this service, which led to this focused inspection, one sadly resulting in the death of a young person. The full outcome of the external investigation into this death has not been published yet.

Another incident resulted in a young person accidentally falling off the roof of the unit. We discovered that despite

this incident not reaching the threshold of a reportable serious incident, the service had decided to classify it as one to ensure completion of a comprehensive investigation, and to identify any lessons learned.

Reporting incidents and learning from when things go wrong

Staff demonstrated that they knew what to report and how to report it. An electronic reporting system was in place for staff to use to report incidents. The ward manager fed back learning to staff following an incident during team meetings. This ensured staff received education on what changes could be made in their future work with young people or if they had done the right thing.

Staff stated that following incidents, both staff and young people were offered debriefs and counselling. Staff said the support following incidents was very positive, and they had access to external support if necessary. Following serious incidents, the service had also offered additional support to all the parents of young people. Staff at the service were able to demonstrate learning which had taken place following the serious incidents and how this learning was embedded into the team culture and practices.

Are services effective?

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

Our findings

Since our inspection in November 2017 we have received no information that would make us re-inspect this key question.

Are services caring?

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

Our findings

Since our inspection in November 2017 we have received no information that would make us re-inspect this key question.

Are services responsive to people's needs?

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

Our findings

Since our inspection in November 2017 we have received no information that would make us re-inspect this key question.

Are services well-led?

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

Our findings

Since our inspection in November 2017 we have received no information that would make us re-inspect this key question.