STAFFING ISSUES AT BAC

In 1986, Barrett had

Nursing staff	Health Professionals	Medical Staff
28	6	3

All of these were fully funded positions. In addition 2 to 3 student nurses (equivalents of TNEPs) were attached to the unit in supernumerary positions. The roster was closed – all nursing staff were permanent, and none were required from other areas of the hospital.

Currently Barrett has

Nursing staff	Health Professionals	Medical Staff
20.9	4.5	1.8

Current staffing includes 3 TNEPs included in the nursing roster, the Speech and Language Pathologist, in covering the adult wards is only 0.25, and one of the Occupational Therapist positions has been abolished, but temporarily extended for another 3 months.

In summary, there has been greater than 25% reduction in staffing over the past 25 years. At the same time, there is a significant increase in acuity, complexity, severity and impairment with treatment of less severe cases with the expansion of community CYMHS clinics and the establishment of acute inpatient units.

By comparison, the 12 bed Walker unit in Sydney (our equivalent in NSW) has

Nursing staff	Health Professionals	Medical Staff
23	5	2.5

This is similar to the equivalent inpatient units in the UK, although a 12 bed unit there may have 20 – 23 nursing staff, and 4 Health Professionals.

Given that we are usually managing 15 – 20 adolescents (there are circumstances in which we will reduce numbers), our staffing is very lean by national or international comparisons. How have we managed this efficiency?

Over the years we have developed much more targeted treatment programs, and have articulated and developed a comprehensive rehabilitation program which I believe is world class. Roles have become more defined, and we truly use our multidisciplinary skills to maximum potential. I know from when I chaired the CYMHS Clinical Collaborative, that the number of face to face interventions each week provided by clinicians exceeds that of Community CYMHS clinicians. As we have become more rigorous in entering POS data, this will become quite evident.

The ratio of clinicians to adolescents has varied over the past 10 years. After a long period of bed block in 2008 – 2010, beds became available. Community CYMHS and acute inpatient units reduced their referrals, although this was identified as being associated with longer stays in acute inpatient units and poorer outcomes. (Acute inpatient units did not experience the same pressure on beds then as they do now, and had capacity to absorb this.) When beds did become available, there was a lag in referrals.

The second reason in late 2011 to the first quarter of 2012 was the level of high acuity among the adolescents – [redacted]months of having at least [redacted]adolescents continually on continuous observations. We had a reduced capacity to manage any more.

This coincided with the third reason, and a factor which definitely impacted on efficiency. During the same period, we lost several regular staff, and many staff were on short term contracts. On some shifts, only one regular staff member would be rostered on. The loss of staff who knew the patients, could recognise warning signs, who could appropriately intervene made it unsafe to try to admit more. Use of both prn medications and seclusion increased during this period – both unsatisfactory practices.

But the ratio of clinicians to patients is only one measure of efficiency. Another measure is a hypothetical "optimal time" an adolescent spends in the unit vs. the real time they spend. Of course, this can only be guessed at. I will link this to a third measure of efficiency – how long outcomes on discharge are sustained into the community.

There are two major staffing issues which impact on efficiencies in these areas – the numbers and experience/training of staff. I will address these issues specifically with respect to both Occupational Therapists and Nurses.

The role of the OT became more defined in the latter part of the 1990's. We were aware that the gains made during admission were not sustained during discharge. A clear rehabilitation focus was enunciated and developed that involved all staff in the day to day activities of the adolescent. In addition, OTs would assess an adolescent and develop a specific rehabilitation plan implementation by all staff, provide individualised rehabilitation activities which may be generalised to include other staff, as well as identify and implement multiple transitional activities to reintegrate an adolescent within a community. This is time consuming work. It is on top of the multiple other services provided by the OTs – providing sensory and perceptuomotor assessments and guiding staff on the day to day implications of any difficulties, developing the sensory room, and training staff in its use (we were at the forefront of using this intervention), assessing life skills, leisure skills and guiding staff in developing programs in to enhance these skills, developing physical activity programs which recently has become recognised as an essential intervention in young people with serious mental illness and developing, organising and facilitating the adventure therapy intervention which adolescents identify as a key experience in their recovery. It was clear by 1999 that we needed a second OT, and the position was created from a generic leisure activities co-ordinator.

The abolition of the second OT will severely limit the above activities. We will be compromised on all rehabilitation and transition interventions. Adolescents will stay longer. The evidence for this is from periods of time when there were limitations on filling an OT position, or when one has been on extended leave. The pressure on the remaining OT will almost inevitably lead to burn out.

Two OTs will be necessary whatever the future of the unit. It is the minimum if we continue as an inpatient service or we will require more if we transition to another type of service.

The second issue affecting the efficiency of treatment is the absence of the closed roster for Nursing staff. I described above the impact of this on the unit in early 2012. It also has a major impact on therapeutic efficiency. The situation has improved in recent months, but it is still sub-optimal. I have the highest regard for those nurses who put the care for the adolescent above their own future.

I recognise the difficulties in providing stability in this uncertain environment, but any possible future model that I can envisage must retain the current core of Nurses and enhance their skills. I know from conversations with senior Nurses in the acute adolescent inpatient units, from conversations with adolescents who have been to these units, and conversations with my psychiatrist colleagues that our Nurses have expertise which must be retained, expanded upon and enhanced for working with young people with severe and complex mental illness with severe impairment in whatever context they are cared for in the future. Any alternative model to that recommended by the ECRG will in fact require more nurses.

The Quality Network for Inpatient CAMHS (like an ACHS for inpatient adolescent units in the UK) publishes standards for inpatient units. The following two sections are highly relevant.

2.1.5 *The unit is staffed by permanent staff, and bank and agency staff are used only in exceptional circumstances e.g. in response to additional clinical need*
Guidance: A CAMHS inpatient unit is likely to have a problem with over-use of agency nurses if more than 15% of staff are agency staff during a week or if more than one member of staff on a shift are from an agency. Agency staff should not be used for more than two shifts in a day.
Ref 8, pg 19: 'Service user feedback reinforces the importance of a regular and stable workforce which enables the development of therapeutic relationship and trust in providing support at distressing times. The National Audit of Violence (HC 2005) found that lack of leadership, inexperienced ward staff combined with an over reliance on bank and agency staff can have a negative effect upon the continuity of care and overall safety of the acute inpatient ward.'

and 2.1.6

Where bank and agency staff are used, they are familiar with the service and experienced in working with young people with mental health problems.

I have observed some adolescents stalled for weeks because there are insufficient Nurses that they know to speak to on weekends and at night. It is an issue which the adolescents have brought up in the Business Unit Meeting, and parents have expressed their concerns.

In 2000 we had 21.9 regular staff + nurses in training. This consisted of the NUM, 4 CNs (including the Community Liaison Clinical Nurse) and 16.9 regular Registered Nurses. The reduction to 12 regular Registered Nurses really stretches the resources to provide care, treatment and rehabilitation activities, particularly when there may be long term sick leave, or any other type of leave.

I realise these are constrained times for budgets. However ensuring nursing staff stability and adequate numbers should be cost neutral, but a high priority in a patient focussed care system.