Unannounced Follow Up Inspection Report

24-25 May 2017

Cloughmore Ward
Bluestone Unit
Craigavon Area Hospital
Southern Health and Social Care Trust

Tel No: 02838366750

Inspectors: Audrey McLellan and Dr Brian Fleming

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Assurance, Challenge and Improvement in Health and Social Care

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service provider from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

Cloughmore is an 18 bedded admission ward in the Bluestone Unit on the Craigavon Area Hospital site. The purpose of the unit is to provide acute assessment and treatment for patients with a psychiatric illness who require care in an inpatient environment. The multidisciplinary team (MDT) consists of a team of nursing staff and health care assistants, two consultant psychiatrists, two doctors, a dietician, a pharmacist, a social worker, a clinical psychologist and an occupational therapist. There were 17 patients on the ward on the days of the inspection and four of these patients had been detained under the Mental Health (NI) Order 1986. One patient's discharge from hospital had been delayed.

3.0 Service details

Responsible person (Acting) : Stephen McNally	**Ward Manager**: Lynsey Erskine
Category of care: Acute Mental Health	**Number of beds:** 18
Person in charge at the time of inspection: Lynsey Erskine	

4.0 Inspection summary

An unannounced follow-up inspection took place over two days on 24-25 May 2017.

The inspection sought to assess progress with findings for improvement raised from the previous unannounced inspection on 14-17 September 2015. This inspection also assessed if Cloughmore Ward was well led.

Evidence of good practice was found in relation to a number of quality improvement projects which staff were continuing to work on. There was also evidence that staff were completing psychological formulations which underpinned care planning and informed relevant models of psychological interventions. The ward had developed a therapeutic activity timetable which included low level psychological therapeutic sessions as well as recreational activities. There were good governance arrangements in place to monitor incidents on the ward and work had been completed with staff to improve relationships within the MDT. It was also positive to note that the Trust had employed a clinical psychologist to work in the Bluestone unit.

Areas requiring improvement were identified in relation to the medical section of the ward round template as it had not been completed each week by medical staff.

The ward environment was clean and tidy during the inspection and staff were available in the communal areas. Staff were observed sitting chatting to patients and encouraging them to participate in ward based activities. Patients appeared relaxed and comfortable in their surroundings.

Views of patients

The inspectors spoke to five patients who all confirmed they were happy with the care and treatment they had received. Patients confirmed they were involved in all aspects of their care and had attended low level psychological sessions and recreational activities. All five patients confirmed they felt safe on the ward and no concerns were raised regarding any aspects of their care and treatment. Patients made the following comments;

"I'm able to go for a coffee with another patient…..if you have a problem the nurses help you…..staff are all very helpful…if you're not well staff listen to you".

"Couldn't be better….everything is explained to me…..I'm treated great…. the doctor explains everything to me in detail…..I was in bad shape when I arrived and I'm much better now….I have found the staff very helpful…..even at night staff are there for me…they have made me tea and toast at night…the attention you get from the minute you come into the ward is first class…everyone treats you so well".

"The consultant is very good…..he has discussed my medication with me…..getting things to do is good on the ward like OT and walks to the shop".

"I go to meetings with the nurses, OT and doctors…staff are grand they are all very caring….I was a bit worried about new patients coming onto the ward but everything has been fine….I don't think there is anything on the ward to improve".

Dr X is very pleasant and the nurses are 100%, staff are all very friendly….it's a very relaxing ward….food is very good"

Views of relatives

There were no relatives available to speak with inspectors on the days of the inspection.

Views of staff

The inspectors spoke to five staff who all confirmed they enjoyed working on the ward and stated that relationships within the MDT had improved after they had attended a team building day. Staff stated they see the benefits of the ward's therapeutic sessions for patients and are enjoying facilitating these groups. Staff stated they have no concerns regarding patient care on the ward.

The findings of this report will provide the Trust with the necessary information to assist them to fulfil their responsibilities, enhance practice and service user experience.

4.1 Inspection outcome

Total number of areas for improvement	1

Out of the 21 areas for improvement 20 have been met and one has been restated for a second time. This has been included in the Provider Compliance Plan (PCP).

5.0 How we inspect

The Inspection was underpinned by:

- The Mental Health (Northern Ireland) Order 1986.
- The Quality Standards for Health & Social Care: Supporting Good Governance and Best Practice in the HPSS, 2006.
- The Human Rights Act 1998.
- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.
- Optional Protocol to the Convention Against Torture (OPCAT) 2002.

The following areas were examined during the inspection:

- Care documentation in relation to four patients.
- Ward environment.
- Therapeutic schedule.
- The operational policy for the ward.
- Incidents and accidents.
- Complaints.
- Health and safety assessments and associated action plans.
- Information in relation to governance, meetings, organisational management, structure and lines of accountability.
- Details of supervision and appraisal records.
- Policies and procedures.
- Staff duty rota.
- Mandatory training records.
- Minutes of patient forum meetings.
- Minutes of ward manager meetings.
- Medicine Kardexes.

During the inspection the inspector observed staff working practices and interactions with patients using a Quality of Interactions Schedule Tool (QUIS).

We reviewed the areas for improvements made at the previous inspection and an assessment of compliance was recorded as met and partially met.

6.0 The inspection

6.1 Review of areas for improvement from the last unannounced inspection 14-17 September 2015

The most recent inspection of Cloughmore Ward was an unannounced inspection. The completed PCP was returned and approved by the responsible inspector. This PCP was validated by inspectors during this inspection.

Areas for Improvement		Validation of Compliance
Number/Area 1 **Ref**: Standard 5.3.1(a) **Stated:** First Time	Risk assessments were not in place for patients using profiling beds and only one patient had a care plan in place. However this had not been reviewed and had not been recorded on the PARIS system with all other care plans.	**Met**
	Action taken as confirmed during the inspection: There was one patient using a profiling bed on the ward. The inspectors reviewed this patient's care documentation and there was evidence that a risk assessment had been completed for this patient in relation to the risks involved in using a profile bed. There was evidence that the patient's risk assessment was reviewed each week at the MDT meetings.	
Number/Area 2 **Ref**: Standard 4.3(m) **Stated:** First Time	All staff did not have up to date mandatory training in place in accordance with the trust's corporate mandatory training policy dated March 2015. RQIA have requested an action plan in relation to this recommendation.	**Met**
	Action taken as confirmed during the inspection: The inspectors reviewed the mandatory training records on the ward for nursing staff. There were some gaps in staff mandatory training however the	

	ward manager had dates arranged to ensure that all staff received up to date training.	
Number/Area 3 **Ref**: Standard 4.3(i) **Stated:** First Time	The ward had an up to date fire risk assessment completed and subsequent action plan. However there was no record of the responsible person who would carry out these actions with a timeline for completion of this work.	**Met**
	Action taken as confirmed during the inspection: The ward had an up to date fire risk assessment completed. This assessment included the responsible person who would carry out the actions with a timeline for completion of each action.	
Number/Area 4 **Ref**: Standard 4.3(i) **Stated:** First Time	The ward ligature risk assessment and action plan was in place which detailed controlled measures. However there was no timescale set for when recommendations would be completed.	**Met**
	Action taken as confirmed during the inspection: The ward had an up to date ligature risk assessment completed. This assessment included the actions required, the responsible person who will action the recommendations and a timeline for completion of each action.	
Number/Area 5 **Ref**: Standard 5.3.1(f) **Stated:** First Time	Personal safety plans were not completed in line with the Promoting Quality Care – Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services May 2010.	**Met**
	Action taken as confirmed during the inspection: The inspector reviewed four sets of care records and there was evidence that these assessments had been completed in line with the Promoting Quality Care – Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services May 2010.	

Number/Area 6 **Ref**: Standard 4.3(i) **Stated:** First Time	The ward had completed an environmental/infection control audit. However there were a number of areas identified in this as 'non compliant' with specific actions required to address each area. However there was no record of a timeline for when these actions would be completed and who the responsible person was. **Action taken as confirmed during the inspection**: The ward sister and the senior domestic supervisor complete a monthly environmental/infection control audit. This included an action plan, a timeline for completion and identified the responsible person.	**Met**
Number/Area 7 **Ref**: Standard 5.3.3(b) **Stated:** First Time	Patients were not involved in designing and managing their own personal safety plans. **Action taken as confirmed during the inspection**: There was evidence in the four sets of care records reviewed that patients were involved in developing and reviewing their personal safety plan. Patients were also asked to sign a record sheet to confirm they agreed with this assessment.	**Met**
Number/Area 8 **Ref**: Standard 5.3.1(f) **Stated:** First Time	Fifteen of the policies and procedures sent to RQIA prior to the inspection had been created prior to 2011 and therefore had not been reviewed within the last four years. RQIA have requested an action plan in relation to this recommendation. **Action taken as confirmed during the inspection**: RQIA received documentation after the previous inspection which confirmed that all policies and procedures relating to the ward had been reviewed and updated.	**Met**
Number/Area 9 **Ref**: Standard 8.3(e) **Stated:** First Time	A number of nursing staff raised concerns regarding their relationship with the medical staff. These staff members stated they felt their opinions were not taken on board and that they had been left to complete tasks which in their opinion should be completed by the multi-disciplinary team. RQIA have requested an action plan in relation to this	**Met**

	recommendation.	
	Action taken as confirmed during the inspection: The trust had arranged a team building day for all staff to attend and this had resulted in honest discussions between all staff members. The inspector spoke to six members of the MDT. All staff advised that relationships between the medical staff had improved. The P.E.R.F.O.R.M.S. (Purpose, Empowerment, Relationships and Communication, Flexibility, Optimal Performance/Productivity, Recognition and Appreciation, Morale and Stress) Team Effectiveness Questionnaire (TEQ) formed part of this team building day.	
Number/Area 10 **Ref**: Standard 5.3.1(f) **Stated:** First Time	The medical section of the ward round template had not been completed each week for patients. Sections on agreed actions and the timeframe for implementation were also not completed in all records reviewed.	**Partially Met**
	Action taken as confirmed during the inspection: The inspector reviewed four sets of care records and there was evidence that agreed actions from the MDT meeting had been recorded which were reviewed each week. However, the medical section in each care record reviewed had not been completed. As this recommendation has been partially met it will be reworded and restated.	
Number/Area 11 **Ref**: Standard 5.3.3(b) **Stated:** First Time	Patients did not attend their MDT meetings each week therefore decisions were made without their involvement.	**Met**
	Action taken as confirmed during the inspection: The inspectors spoke to six patients on the ward who all confirmed that they attend their MDT meetings each week and have the opportunity to meet with the consultant on the ward on when	

	requested.	
Number/Area 12 **Ref**: Standard 5.3.1(a) **Stated:** First Time	There did not appear to be a link between patients' assessed need and the therapeutic interventions they were attending. Therapeutic care plans were not comprehensively completed from each patients' assessed need.	**Met**
	Action taken as confirmed during the inspection: The inspectors review four sets of care records which evidenced that staff had completed psychological formulations for each patient that underpinned care planning and informed relevant models of psychological interventions.	
Number/Area 13 **Ref**: Standard 5.3.1(a) **Stated:** First Time	Therapeutic and leisure activity care plans were not completed from assessed need and a number stated 'to involve in therapeutic activity' without identifying which therapeutic intervention the patients should attend.	**Met**
	Action taken as confirmed during the inspection: The inspectors review four sets of care records and which evidenced that staff had completed psychological formulations for each patient which underpinned care planning and informed relevant models of psychological interventions.	
Number/Area 14 **Ref**: Standard 5.3.1(a) **Stated:** First Time	DOL's care plans were not on the PARIS system but were held in patient's files. The inspectors noted that these care plans had not been reviewed along with the care plans on the PARIS system.	**Met**
	Action taken as confirmed during the inspection: In the four sets of care records reviewed DOL's care plans were completed on the PARIS system. These plans had been reviewed regularly alongside all other care plans.	
Number/Area 15 **Ref**: Standard 6.3.2(b)	Information on the ward performance was not displayed, all staff were not wearing their name badges, there was no information displayed in the MDT team, the day of the ward round, the patients' named nurse/keyworker or who was on duty	**Met**

Stated: First Time	including the doctor. **Action taken as confirmed during the inspection**: The inspectors reviewed the ward environment and there was evidence that information in relation to the ward performance, the MDT team, the day of the ward round, the patients' named nurse/keyworker and who was on duty was displayed. All staff who met with the inspector were wearing their name badges.	
Number/Area 16 **Ref**: Standard 6.3.2(b) **Stated:** First Time	There was no information displayed on Human Rights, the advocacy service, the Mental Health Order or the MHRT. **Action taken as confirmed during the inspection**: Information in relation to human rights, the advocacy service, the Mental Health Order and the MHRT was available to patients.	**Met**
Number/Area 17 **Ref**: Standard 4.3(n) **Stated:** First Time	The average number of banking shifts per week was 12 shifts. **Action taken as confirmed during the inspection**: The ward were still using bank staff on a regular basis as a number of staff had left their posts within the bluestone unit. However a rolling recruitment was in place and a number a new staff were due to take up posts. The trust is also working closely with the colleges to offer newly qualified nurses posts within the bluestone unit. This has also involved setting up a programme for all staff to have their mandatory training in place prior to taking up their position.	**Met**
Number/Area 18 **Ref**: Standard 5.3.1(f) **Stated:** First Time	The ward needed repainted. **Action taken as confirmed during the inspection**: The ward had been repainted	**Met**

Number/Area 19 **Ref**: Standard 5.3.1(f) **Stated:** First Time	The ward does not have an operational policy in place. **Action taken as confirmed during the inspection**: Operational Guidelines for Bluestone Inpatient Unit had been developed in March 2016.	**Met**
Number/Area 20 **Ref**: Standard 5.3.1(a) **Stated:** Second Time	All patients who were using a profiling bed did not have a record in their care documentation explaining the rationale for using this type of bed supported by a risk assessment and care plan. **Action taken as confirmed during the inspection**: Care documentation was in place for the patient who was using a profiling bed on the ward. This included a record of the clinical need for using a profiling bed and an assessment of the risks with measure in place to reduce the likelihood of harm to the patient.	**Met**
Number/Area 21 **Ref**: Standard 8.3(i) **Stated:** Second Time	The Trust had not reviewed and implemented a robust process for obtaining patient information for patients transferring from other trusts to the wards in the Bluestone Unit to ensure that all relevant patient information is promptly available to inform care and treatment plans. RQIA have requested an action plan in relation to this recommendation. **Action taken as confirmed during the inspection**: The trust has worked closely with other trusts to ensure that all relevant information is forwarded to the ward prior to a patient being admitted. Meetings have been held with senior trust representatives and an agreement has been reached regarding the importance of the wards receiving patient information on admission. Staff confirmed that there are better working relationships within the trusts as they now receive patients' risk assessments and an up to date mental health assessment on admission.	**Met**

6.1 Is the Service Well Led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care

Areas of Good Practice

All staff who spoke to the inspectors knew what actions to take if they had concerns regarding the care and treatment of patients on the ward.

Policies and procedures relation to the ward were up to date.

Governance arrangements were in place to monitor admissions, discharge, average length of staff on the ward and occupancy.

There was a defined organisational and management structure in place. Staff who spoke to the inspectors were aware of this structure.

There were appropriate systems in place to record and report incidents, accidents and serious adverse incidents. There was evidence that learning from incidents was cascaded down to staff via the ward manager's meetings.

Staff shortages were appropriately managed and continually reviewed.

Inspectors evidenced improved working relationships between members of the MDT.

Staff from the MDT who met with the inspectors confirmed they had up to date appraisals in place and received supervision in accordance with their professional guidance.

There were some gaps in staff mandatory training however the ward manager had dates arranged to ensure that all staff received up to date mandatory training.

Staff who spoke to the inspectors stated they enjoyed working on the ward and stated they were well supported by their colleagues and the ward manager.

Governance arrangements were in place to monitor the prescription and administration of medication.

There was a pharmacist on the ward who completed audits of the controlled drugs every quarter, reviewed the kardexes and was available to offer staff advice.

There was evidence that staff use a variety of methods to monitor patient experience. After each therapeutic session patients were asked to provide feedback on the session and a suggestion box was available on the ward. There were weekly patient meetings and patients

were asked to complete a satisfaction survey on discharge. There was evidence that the ward manager was collating and analysing this information to assist in improving the service.

It was good to note that staff were involved in a number of quality improvement projects such as;

- Setting up a psychological intervention programme which will be available to all patients in the Bluestone Unit and will be held in the resource centre. It is hoped that when patients are discharged they will continue to complete this programme (Coping with Emotions).
- The ward is in the process of developing a bespoke training package and standards on 'Inpatients with Eating Disorders in a Psychiatric Ward'.
- Staff are in the process of completing a research study on patients' attendance in psychological sessions on the ward.

Areas for improvement

No areas have been identified for improvement

Number of areas for improvement	0

7.0 Provider Compliance Plan

Areas for improvement identified during this inspection are detailed in the provider compliance plan (PCP). Details of the PCP were discussed with senior trust representatives, members of the multi-disciplinary team, ward manager, and ward staff as part of the inspection process. The timescales commence from the date of inspection.

The responsible person must ensure that all areas for improvement identified within the PCP are addressed within the specified timescales. The responsible person should note that failure to comply with the findings of this inspection may lead to escalation action being taken.

7.1 Actions to be taken by the service

The provider compliance plan should be completed and detail the actions taken to meet the areas for improvement identified. The responsible person should confirm that these actions have been completed and return the completed provider compliance plan to Team.MentalHealth@rqia.org.uk for assessment by the inspector by 18 July 2017**.**

Provider Compliance Plan	
The responsible person must ensure the following findings are addressed:	
Area for Improvement No. 1 **Ref:** Standard 5.3.1(f) **Stated:** Second Time **To be completed by:** 20 July 2017	The medical section of the ward round template had not been completed each week for patients.
	Response by responsible individual detailing the actions taken: The Consultant will ensure that the medical section of the MDT template is completed at each MDT meeting. This will be monitored by the Ward Sister for compliance and report to Head of Service and Associate Medical Director.

Name of person (s) completing the PCP	Andrew Ruck		
Signature of person (s) completing the PCP		**Date completed**	10/07/2017
Name of responsible person approving the PCP	Adrian Corrigan		
Signature of responsible person approving the PCP		**Date approved**	10/07/2017
Name of RQIA inspector assessing response	Audrey McLellan		
Signature of RQIA inspector assessing response		**Date approved**	27/7/17

Please ensure this document is completed in full and returned to MHLD.DutyRota@RQIA.org.uk from the authorised email address

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