Silverwood Ward
Address: Bluestone Unit
Craigavon Area Hospital
68 Lurgan Road
Portadown BT63 5QQ

Dates of Inspection Visit: 9 – 11 August 2016

Names of Inspectors: Alan Guthrie, Dr Oscar Daly, Patrick Convery

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Assurance, Challenge and Improvement in Health and Social Care

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This report describes our judgement of the quality of care at Silverwood ward. It is based on a combination of what we found when we inspected and from a review of all of the information available to The Regulation and Quality Improvement Authority (RQIA). This included information given to us from patients, the public and other organisations.

This inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in this service. The findings reported on are those that came to the attention of RQIA during the course of this inspection while assessing the four stakeholder outcomes under this year's theme of Patient Centred Care. The findings contained in this report do not exempt the trust from their responsibility the Mental Health (Northern Ireland) Order 1986 and the Department of Health (DoH) standards. It is expected that the areas for improvement outlined in this report will provide the trust with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

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1.0 Details of Ward

Silverwood Ward is a mental health acute admission ward located in the Bluestone Unit on the Craigavon Area Hospital site. The ward provides single room accommodation for up to 18 patients. There were 14 patients on the ward on the days of the inspection and three patients were on leave. Four patients were detained under the Mental Health (NI) Order 1986.

Patients have access to the multi-disciplinary team which includes nursing, psychiatry, social work and occupational therapy (OT) staff. Patients on the ward can also access to an independent advocacy service.

2.0 Summary of this Inspection

This inspection focused on the theme of Person Centred Care. This means that patients are treated as individuals, and the care and treatment provided to them is based around their specific needs and choices.

On the days of the inspection RQIA noted that Silverwood ward was well maintained and welcoming. The atmosphere within the ward was relaxed and patients presented as being at ease and comfortable.. Inspectors witnessed that ward staff provided compassionate care and patients could access support as required. Patients stated that the care and treatment they had received was good and staff were approachable, easy to talk to and caring and supportive.

The ward's environment was therapeutic and ward staff maintained the ward's side garden to a very high standard. The ward was clean and it was good to note that support staff reflected positively on their role and the support they received from the rest of the MDT. Inspectors noted the ward's atmosphere to be relaxed, calm and patient centred. Patients presented as content in their surroundings and those who met with inspectors stated that they felt safe on the ward.

The leadership and management within the ward was of a high standard. This was evidenced through patient experience, comments from staff and the management of the ward's processes. Staff appeared to work well together and the team provided placement experiences for student nurses. Inspectors met with one student who described their experience of the ward as excellent and a great learning opportunity.

Four priority one areas for improvement have been made. These concern the review of one patient's legal status, records of patient/staff meeting minutes and full completionof patient risk assessments. A final priority one area for improvement relates to the detail in recording the use of PRN medication. One priority two area for improvement (fitting of the ward's televisions) and two priority three areas for improvement have been made. The priority three areas for improvement relate to the availability of a full time OT and the transfer of restrictive physical intervention record onto the trust's Datix system.

Follow up on Previous Inspection Recommendations

Eight recommendations were made following the most recent inspection on 27 August 2015. All of the recommendations had been implemented in full.

1. Inspectors noted that Silverwood's ward manager remained in the role of designated officer. However, it had been agreed that ward managers within Bluestone would not undertake this role where vulnerable adult referrals had been received relating to the ward for which they were responsible.

2. Recovery plans reviewed by inspectors included assessment and interventions in relation to each patient's physical health care needs. Patients' physical health was reviewed on a regular basis.

3. Recovery care plans reviewed by inspectors evidenced the use of restrictions had been appropriately assessed and monitored. A summary of the effect that the recovery plan had on patients' rights and liberty was provided and inspectors noted the recovery plans to be patient centred, continually reviewed and comprehensive.

4. All patient recovery plans had been centralised onto the trust's PARIS electronic patient information system.

5. The ward's environment was clean, fresh smelling and well maintained. Painting work had been refreshed. The ward manager informed inspectors that they had no concerns in being able to request further decorating/painting work as required.

6. The ventilation in the sitting room/quiet room had been upgraded. The room was airy and appropriate to the needs of the patient group.

7. The ward's patient information booklet/pack had been updated to reflect all blanket and potential individual restrictions that patients may experience whilst on Silverwood ward.

8. Arrangements for the maintenance of the outside garden/smoke area had been improved. Inspectors were informed that the area was visited and maintained by estates services as required.

3.0 How we Carried Out this Inspection

RQIA's programmes of inspection, review and monitoring of mental health legislation focus on four specific and important key stakeholder outcomes:

Is care safe?
Is care effective?
Is care compassionate?
Is the service well led?

What the inspectors did:

- Reviewed a range of information relevant to the facility sent to RQIA before the inspection. This included policies and procedures, staffing levels, ward aims and objectives and governance protocols.
- Talked to patients, carers and staff.
- Observed staff working practices and interactions with patients on the days of the inspection.
- Reviewed other documentation on the days of the inspection. This included care records, incident reports, multi-disciplinary procedures and staff training records.
- Reviewed progress since the last inspection.

At the end of the inspection the inspector(s):

- Commended areas of good practice.
- Shared the inspection findings with staff.
- Highlighted areas for improvement.

4.0 What People Said about this Service

Patients Stated:

During the inspection inspectors met with four patients. Three of the patients completed a questionnaire. Patients stated that the staff were helpful and supportive. Two patients recorded that they were fully involved in their care and treatment. One patient recorded that they were involved in some decisions about their care and treatment. All three patients stated that they had felt better since being admitted to the ward.

Patient involvement in their care and treatment was observed by inspectors. Staff were observed asking patients for their consent prior to providing the patient with support. Patient involvement was also detailed in patient care records. All of the patients who spoke to inspectors stated that ward staff treated them with dignity and respect. Patients also informed inspectors that staff listened to them and took their views into account.

Patients Said:

"The staff treat you the proper way."

"It's good."

"Staff try and keep you calm."

"The staff look after you well",

"Staff are all right."

"I get on with the staff the best."

"The nurses work really hard."

"I have no concerns."

During the inspection patients' relatives were invited to meet with an inspector. No relatives were available to meet with an inspector. Two relatives returned questionnaires post inspection. Both questionnaires were complimentary regarding staff approach, access to staff and the quality of care provided.

Relatives Stated:

"The staff are really good."

"I have no complaints."

Staff Stated:

Inspectors met with nine members of the ward's multi-disciplinary team (MDT) incorporating the views of clinical and support staff. Staff told inspectors that they felt their opinion was valued, listened to and considered. Staff stated that the MDT worked effectively and provided a good standard of care to patients. Staff reflected positively on their role within the ward and stated that they enjoyed working on the ward. Leadership within the ward was described as good and staff reported no concerns regarding their ability to access training and supervision.

Inspectors met with five members of nursing staff which included a student nurse. Staff demonstrated understanding of the ward's ethos, purpose and outcomes. Nursing staff stated that they felt supported and the ward was patient centered promoting a least restrictive practice environment. Staff reported no concerns regarding their role and responsibilities. Whilst staff discussed the challenges of supporting patients who presented as unwell with a high level of associated risk, it was positive to note that staff stated the ward was effective and the outcomes for patients were good.

Clinical staff informed inspectors that the introduction of all records being retained in electronic format remained challenging. The lead Occupational Therapist (OT) provided temporary part time input to patients on the ward. The OT provided a range of activities relevant to the needs of the patient group. Inspectors were concerned to note that the trust had attempted to appoint a temporary full time OT without success. Inspectors were informed that this process had been delayed due to Business Service Organisation administration systems. This issue is discussed in the quality improvement plan.

Medical staff stated that ward processes were effective and the ward benefitted from good leadership and a supportive patient centred MDT. Medical staff reported no concerns regarding the governance of care and treatment practices.

5.0 Our Assessment of the Four Stakeholder Outcomes

5.1 Is Care Safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

Key Indicator S1 - There are systems in place to ensure unnecessary risks to the health, welfare or safety of patients are identified, managed and where possible eliminated.

Examples of Evidence:

- ✓ Patient care records reviewed by inspectors evidenced patient involvement in their care and treatment plans.
- ✓ Care and treatment provided to each patient was individualised, based on the assessed needs of the patient and reviewed regularly.

Area for Improvement:

- ✗ Two patient kardexs evidenced no indication or minimum intervals recording for pro re nata (PRN) medication.

Key Indicator S2 - The premises and grounds are safe, well maintained and suitable for their state of purpose.

Inspectors assessed the ward's physical environment using a ward observational tool and check list.

Examples of Evidence

Ward Environment

- ✓ Patients reported that they felt safe on the ward.
- ✓ A ligature point risk assessment, a fire risk assessment and a fire evacuation drill report had been completed and were up to date.

Area for Improvement:

- ✗ Fitting and securing the ward's televisions.2017.

Key Indicator S3 - There are at all times, suitably qualified, competent and experienced persons working in the facility.

Examples of Evidence

- ✓ Staff who met with inspectors demonstrated appropriate knowledge, skill and understanding regarding ward processes.
- ✓ Staff had completed up to date mandatory training.

- ✓ Staff supervision and appraisals were completed in accordance with the required standards.
- ✓ Staff informed inspectors that they enjoyed working on the ward and that the MDT worked well together.

Area for Improvement:

- ✗ None identified.

Key Indicator S4 – Patients are detained appropriately with information provided about their rights and how to make a complaint.

Examples of Evidence:

- ✓ Patients were provided with appropriate information regarding their rights.
- ✓ Patients knew how to make a complaint and how to access the advocacy service.

Area for Improvement:

- ✗ Inspectors evidenced that the legal status of one patient, subject to the Mental Health (Northern Ireland) Order 1986, required to be reviewed in relation to the detention process.

5.2 Is Care Effective?

The right care, at the right time in the right place with the best outcome.

Key Indicator E1 - Comprehensive co-produced personal well-being plans/care plans are in place to meet the assessed needs of patients.

Care and treatment is evaluated for effectiveness. Effective discharge planning arrangements are in place.

Examples of Evidence:

- ✓ Patient care records evidenced that care and treatment plans were based on each patient's individually assessed needs.
- ✓ Patients who met with inspectors reported that they were active participants in their care and treatment planning. Patient recovery care plans were completed in a manner that reflected the patient's perspective.
- ✓ Discharge planning commenced upon each patient's admission. Records demonstrated that the MDT was proactive in trying to ensure that each patient's discharge was completed in an appropriate and timely manner.
- ✓ One patient's discharge from the ward had been significantly delayed. It was positive to note the ward's senior management team continued to implement appropriate steps in relation to the patient's discharge plan.

✓ Patient care records were centrally retained in the trust's PARIS patient information system.

Areas for improvement:

✘ Sections within patient risk assessments were not completed in full. This included sections relating to patient's dependents, carer's views, carer's assessment and collateral information.

✘ The trust had been unable to appointment a temporary Occupational Therapist due to delays within the Business Services Organisation recruitment processes.

Key Indicator E2 - Autonomy and Independence is promoted and the use of restrictive practice(s) is minimised.

Examples of Evidence:

✓ The ward environment was modern, enabling and well maintained.

✓ Restrictive practices were implemented on the basis of each patient's individualised assessed needs and associated risks. Restrictions were used proportionally and in accordance to trust and regional standards.

✓ Ward staff demonstrated a high level of skill in relation to the importance of measuring the use of restrictive practices against each patient's rights.

Area for Improvement:

✘ The Restrictive Physical Intervention form was not available on individual patient files on the Trust's DATIX system

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5.3 Is Care Compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

Key Indicator C1 - There is a culture/ethos that supports the values of dignity and respect and patients are responded to compassionately.

Observations - Effective and therapeutic communication and behaviour is a vitally important component of dignified care. The Quality of Interaction Schedule (QUIS) is a method of systematically observing and recording interactions whilst remaining a non-participant. It aims to help evaluate the type of communication and the quality of communication that takes place on the ward between patients, staff, and visitors.

Inspectors completed direct observations using the QUIS tool during the inspection and assessed whether the quality of the interaction and communication was positive, basic, neutral, or negative.

- **Positive Social (PS)** - care and interaction over and beyond the basic care task demonstrating patient centred empathy, support, explanation and socialisation.
- **Basic Care (BC)** – care task carried out adequately but without elements of psychological support. It is the conversation necessary to get the job done.
- **Neutral** – brief indifferent interactions.
- **Negative** – communication which is disregarding the patient's dignity and respect.

Examples of Evidence:

Observations of interactions between staff and patients/visitors were completed throughout the days of the inspection. There were three interactions recorded in this time period. The outcomes of these interactions were as follows:

Positive	Basic	Neutral	Negative
100%	0%	0%	0%

- ✓ Interactions between patients and staff were witnessed by inspectors to be supportive and positive. Staff were available throughout the ward.
- ✓ Inspectors met with four patients. Patients stated that being on the ward was helping them to recover. Staff were described as being supportive and easy to talk to.
- ✓ Patients were involved in planning their care and treatment.
- ✓ All of the patients who spoke to inspectors stated that they were treated with dignity and respect.

Area for Improvement:

- ✗ None identified.

Key Indicator C2 - **There are systems in place to ensure that the views and opinions of patients, and/or their representatives are sought and taken into account in all matters affecting them.**

Examples of Evidence:

- ✓ Patients who met with inspectors stated that staff kept them informed about their care and treatment plans.
- ✓ Patients stated that their views were sought and considered.
- ✓ Patients could access the advocacy service as required.
- ✓ The ward advocate stated that the staff team considered and responded to patient requests.

Area for Improvement:

- ✘ Minutes from the patient/staff meeting did not record the actions that had been taken by staff in addressing the concerns/requests raised by patients.

5.4 Is The Service Well Led?

There is effective leadership, management and governance which create a culture focused on the needs and experiences of patients in order to deliver safe, effective and compassionate care.

Key Indicator WL1 - There are appropriate management and governance systems in place to meet the needs of patients.

Examples of Evidence:

- ✓ Staff who met with inspectors stated that they understood their role and responsibilities and the actions they should take to safeguard patients and their families.
- ✓ Policies and procedures were accessible to all staff and updated as required.
- ✓ Incidents had been recorded appropriately and included a description of the circumstances and the action taken.
- ✓ Patient care records evidenced that safeguarding referrals were appropriately managed and incidents had been recorded and reviewed in line with trust policy and procedure.
- ✓ There were good working relationships evident between the MDT members.

Area for Improvement:

- ✘ None identified.

Key Indicator WL2 - There are appropriate management and governance systems in place that drive quality improvement.

Examples of Evidence:

- ✓ There were appropriate systems in place to record and report incidents, accidents and serious adverse incidents.
- ✓ Patient forum meetings were held on a monthly basis and facilitated by the ward's advocate. The advocate stated that patient concerns were addressed.
- ✓ Two questionnaires completed by carers/relatives and returned to RQIA were positive and complementary about the ward.

Area for Improvement:

- ✘ None identified.

Key Indicator WL3 - There is a clear organisational structure and all staff are aware of their roles, responsibility and accountability within the overall structure. There are appropriate supervision arrangements in place.

Examples of Evidence:

- ✓ Staff understood their role and responsibilities within the ward.
- ✓ There was a clear management structure identifying the lines of responsibility and accountability.
- ✓ Staff reported that they had received up to date mandatory training, supervision and appraisal. Nurse training records were up to date.

Area for Improvement:

- ✘ None identified.

Key Indicator WL4 - There are effective staffing arrangements in place to meet the needs of the patients.

Examples of Evidence:

- ✓ Staff shortages were appropriately managed and continually reviewed.
- ✓ Inspectors evidenced good working relationships between the members of the MDT.
- ✓ Staff informed inspectors that they felt supported.

Areas for improvement:

- ✘ The ward did not have a full time Occupational Therapist in post at the time of inspection.

6.0 Good Practice Noted

Inspectors evidenced that the ward staff team continued to improve practices on the ward. This included the continued progression of electronic records, development of the ward's therapeutic and garden spaces and continued review of the ward's environment to minimise risks to patients.

The ward's MDT worked effectively together and staff informed inspectors that they enjoyed working on the ward.

7.0 Quality Improvement Plan

Areas for improvement are summarised below. The trust, in conjunction with ward staff, should provide a compliance plan to RQIA detailing the actions to be taken to address the areas identified.

Key areas for improvement were discussed with the ward manager and other staff from the trust involved in providing care/treatment to patients in this ward as part of the inspection process.

The timescale for action on the areas for improvement commenced from the day of the inspection. The quality improvement plan requires to be completed by the trust detailing the actions the trust intend to take to make the required improvement and returning to RQIA within 28 days of receipt.

On return to RQIA the quality improvement plan will be assessed by the inspector.

	Areas for Improvement	Timescale for Implementation in Full
Priority 1		
1	Inspectors evidenced that the legal status of one patient, subject to the Mental Health (Northern Ireland) Order 1986, required to be reviewed in relation to the detention process.	5 October 2016
2	Sections within patient risk assessments were not completed in full. This included sections relating to patient's dependents, carers views, carers assessment and collateral information.	5 October 2016
3	Minutes from the patient/staff meeting did not record the actions that had been taken by staff in addressing the concerns/requests raised by patients.	5 October 2016
4	Two patient kardexs evidenced no indication or minimum intervals recording for pro re nata (PRN) medication.	5 October 2016
Priority 2		
5	Fitting and securing the ward's televisions prior to May 2017.	8 December 2016
Priority 3		
6	The trust had been unable to appointment a temporary occupational therapist due to delays within the Business Services Organisation recruitment processes.	8 March 2017
7	The restrictive practice assessment completed with each patient was not available on the trust's Datix system.	8 March 2017

Definitions for Priority Improvements

PRIORTY	TIMESCALE FOR IMPLEMENTATION IN FULL
1	This can be anywhere from **24 hours to 4 weeks from the date of the inspection** – the specific date for implementation in full will be specified
2	Up to **3 months** from the date of the inspection
3	Up to **6 months** from the date of the inspection

HSC Trust Quality Improvement Plan

WARD NAME	Silverwood	WARD MANAGER	Angeline Magennis	DATE OF INSPECTION	9 – 11 August 2016
NAME(S) OF PERSON(S) COMPLETING THE IMPROVEMENT PLAN	Angeline Magennis		NAME(S) OF PERSON(S) AUTHORISING THE IMPROVEMENT PLAN		

Recommendations are made in accordance with The Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS, 2006.

The areas where improvement is required, as identified during this inspection visit, are detailed in the Inspection Report and Quality Improvement Plan (QIP).

The completed QIP should be completed and returned to team.mentalhealth@rqia.org.uk from the HSC Trust approved e-mail address, by 6 October 2016.

Please password protect or redact information where required.

PRIORTY	TIMESCALE FOR IMPLEMENTATION IN FULL
1	This can be anywhere from **24 hours to 4 weeks from the date of the inspection** – the specific date for implementation in full will be specified
2	Up to **3 months** from the date of the inspection
3	Up to **6 months** from the date of the inspection

Part A

Priority 1: Please provide details of the actions taken by the Ward/Trust in the timeframe **immediately** after the inspection to address the areas identified as **Priority 1**.

Area identified for Improvement	Timescale for full implementation	Actions taken by Ward/Trust	Attached Supporting Evidence	Date completed
Key Outcome Area – Is Care Safe? Inspectors evidenced that the legal status of one patient, subject to the Mental Health (Northern Ireland) Order 1986, required review. **Minimum Standard: Quality Standard 5.3.1 (a)** This area has been identified for improvement for the **first** time.	5 October 2016	This patients detention is currently under weekly review. A long term treatment plan including placement options is being formulated in collaboration with the patient. The patient has visited several potential placements. Once the least restrictive treatment plan is available it is anticipated that the patient will return to a voluntary status. The patient is aware that the opportunity to apply to the Mental heath review tribunal is available. All statutory reviews under the Mental Health Order will be adhered to.		30.9.16
Key Outcome Area – Is Care Safe? Two patient kardexs evidenced no indication or minimum intervals recording for pro re nata (PRN) medication. **Minimum Standard: Quality Standard 5.3.1 (f)**	5 October 2016	All kardex's have been reviewed and amended to evidence the indication for use and the minumum intervals for PRN medication.	The Junior Doctors have commenced a unit wide audit of the kardexs focusing primarily on the prescription of PRN medication. This evidence will be presented at a medical teaching seminar and shared with all disciplines to ensure compliance.	30.9.16

This area has been identified for improvement for the **first** time.				
Key Outcome Area – Is Care Effective? Sections within patient risk assessments were not completed in full. This included sections relating to patient's dependents, carers views, carers assessment and collateral information. **Minimum Standard: Quality Standard 5.3.1 (a)** This area has been identified for improvement for the **first** time.	5 October 2016	All sections of the patients risk assessments have now been completed in full.	An audit is carried out weekly by the ward staff to ensure that all sections have been completed. The Bluestone Unit is currently looking at ways to improve documention and to minimise duplication. This is being highlighted with all wards.	30.9.16
Key Outcome Area – Is Care Compassionate? Minutes from the patient/staff meeting did not record the actions that had been taken by staff in addressing the concerns/requests raised by patients. **Minimum Standard: Quality Standard 5.3.1 (a)** This area has been identified for improvement for the **first**	5 October 2016	A new template has been devised to evidence that all actions taken are recorded and fed back at the following patient/staff meeting.		30.9.16

time.				

Part B

Priority 2: Please provide details of the actions proposed by the Ward/Trust to address the areas identified for improvement. The timescale within which the improvement must be made has been set by RQIA.

Area identified for improvement	Timescale for improvement	Actions to be taken by Ward	Attached Supporting Evidence	Date completed
Key Outcome Area – Is Care Safe? Fitting and securing the ward's televisions prior to May 2017. **Minimum Standard: Quality Standard 5.3.1 (f)** This area has been identified for improvement for the **first** time.	8 December 2017	This has been escalated to the Head of Service and Estates. Estates are currently looking at different design options and costings.		

Part C

Priority 3: Please provide details of the actions proposed by the Ward/Trust to address the areas identified for improvement. The timescale within which the improvement must be made has been set by RQIA.

Area identified for improvement	Timescale for improvement	Actions to be taken by Ward	Attached Supporting Evidence	Date completed
Key Outcome Area – Is Care Effective? The trust had been unable to appointment a temporary	8 March 2016	This has been escalated to the Assistant Director of HR. The post is being curently offered to a new candidate.		

Occupational Therapist due to delays within the Business Services Organisation recruitment processes. **Minimum Standard: Quality Standard 5.3.3 (d)** This area has been identified for improvement for the **first** time.				
Key Outcome Area – Is Care Effective? The restrictive physical intervention record completed with each patient when a physical intervention is required was not available on the trust's PARIS system. **Minimum Standard: Quality Standard 5.3.1 (a)** This area has been identified for improvement for the **first** time.	8 March 2016	The Restrictive Physical Intervention form (RPI) has been amended as part of the work of the Trustwide Restrictive Intervention Group. It will be used by all care directorates. The amended form is with the IT Dept for development on DATIX. In the interim, the current paper version is being used . A Copy of this form is retained in the patients paper notes, until an effective system of uploading and retrieving from PARIS is available.		

TO BE COMPLETED BY RQIA

Inspector comment (delete as appropriate)	Inspector Name	Date
I have reviewed the Trust Improvement Plan and I am satisfied with the proposed actions or I have reviewed the Trust Improvement Plan and I have requested further information		
I have reviewed additional information from the Trust and I am satisfied with the proposed actions		