The Regulation and Quality Improvement Authority

Downe Dementia

Downe Hospital

South Eastern Health & Social Care Trust

Unannounced Inspection Report

Date of inspection: 22 June 2015

npm national preventive mechanism

informing and improving health and social care

www.rqia.org.uk

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Our Vision, Purpose and Values

Vision

To be a driving force for improvement in the quality of health and social care in Northern Ireland

Purpose

The Regulation and Quality Improvement Authority (RQIA) is the independent health and social care regulator in Northern Ireland. We provide assurance about the quality of care, challenge poor practice, promote improvement, safeguard the rights of service users and inform the public through the publication of our reports.

Values

RQIA has a shared set of values that define our culture, and capture what we do when we are at our best:

- **Independence** - upholding our independence as a regulator
- **Inclusiveness** - promoting public involvement and building effective partnerships - internally and externally
- **Integrity** - being honest, open, fair and transparent in all our dealings with our stakeholders
- **Accountability** - being accountable and taking responsibility for our actions
- **Professionalism** - providing professional, effective and efficient services in all aspects of our work - internally and externally
- **Effectiveness** - being an effective and progressive regulator - forward-facing, outward-looking and constantly seeking to develop and improve our services

This comes together in RQIA's Culture Charter, which sets out the behaviours that are expected when employees are living our values in their everyday work.

Contents

1.0 Introduction

The Regulation and Quality Improvement Authority (RQIA) is the independent health and social care regulator in Northern Ireland. We provide assurance about the quality of care, challenge poor practice, promote improvement, safeguard the rights of service users and inform the public through the publication of our reports.

RQIA's programmes of inspection, review and monitoring of mental health legislation focus on three specific and important questions:

Is Care Safe?

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

Is Care Effective?

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

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

2.0 Purpose and Aim of this Inspection

To review the ward's progress in relation to recommendations made following previous inspections.

To meet with patients and / or their representatives to discuss their views about their care, treatment and experiences.

To assess that the ward physical environment is fit for purpose and delivers a relaxed, comfortable, safe and predictable environment.

To evaluate the type and quality of communication, interaction and care practice during a direct observation using a Quality of interaction Schedule (QUIS).

2.1 What happens on inspection

What did the inspector do:

- reviewed the quality improvement plan sent to RQIA by the Trust following the last inspection(s)
- talked to patients, carers and staff
- observed staff practice on the days of the inspection
- looked at different types of documentation

At the end of the inspection the inspector:

- discussed the inspection findings with staff
- agreed any improvements that are required

After the inspection the ward staff will:

- send an improvement plan to RQIA to describe the actions they will take to make any necessary improvements

3.0 About the ward

The Downe Dementia assessment and treatment unit is a twenty bedded mixed gender ward. The ward provides assessment, care and treatment to patients with dementia who may present with behaviours that are distressing. There were fourteen patients on the day of the inspection; nine patients were detained in accordance with the Mental Health (NI) Order 1986.

Patients have access to multi-disciplinary team consisting of psychiatry, medical, nursing, occupational therapy and social work. Access to psychology, physiotherapy, speech and language therapy and dietetics is by referral.

The ward manager was in charge on the day of the inspection.

4.0 Summary

Progress in implementing the recommendations made following the previous inspection carried out on 22 & 23 January 2015 were assessed during this inspection. There were a total of seven recommendations made following the last inspection

It was good to note that six recommendations had been implemented in full.

One recommendation had not been met. This recommendation will be restated for a second time following this inspection.

The inspector noted that the ward had introduced a robust audit of patient care documentation. The tool was completed monthly and a mechanism was

in place to address any deficits in the care documentation with the responsible staff. There was a low turnover of staff on the ward. Staff have also been nominated for an award by the palliative care team.

The lay assessor met with two patients and two relatives on the ward. Patients and relatives spoke positively about the staff on the ward. Both patients and relatives indicated that care was safe and compassionate on the ward. However, responses in relation to questions on effective care were mixed.

The ward environment was observed to be fit for purpose and delivered a relaxed and safe environment. The ward had a dementia friendly design. The ward was spacious which enabled patients to walk around independently. Signage around the ward was of a good size and easily seen. Access within the ward was open. The ward has won several awards for their dementia friendly design.

The ward atmosphere was busy. Staff were observed to engage positively with patients. Staff were attentive and interacted promptly and positively when supporting patients with their care needs. Staff were also observed offering constant reassurance to patients who were distressed and / or confused. Staff also were considerate to patient's visitors.

The inspector noted that all beds on the ward were profiling beds and were included in the ward environmental risk assessment. However, there was no evidence of any individualised ligature risk assessments or management plans, which should have been completed in accordance with the Northern Ireland Adverse Incident Centre (NIAIC) – EFA/2010/006, safety alert self-harm associated with profiling beds. A recommendation has been made.

Ward staff, patients and their representatives highlighted that recreational and therapeutic activities are not always available. Ward staff highlighted that the reduction in occupational therapy services had an impact on the delivery of therapeutic and recreational activities on the ward. A recommendation has been made.

4.1 Implementation of Recommendations

Two recommendations which relate to the key question "**Is Care Safe**?" were made following the inspection undertaken on 22 & 23 January 2015.

These recommendations concerned the ward assistive technology systems and the completion of falls risk assessments in accordance with guidance.

The inspector noted that both recommendations had been fully implemented. The ward had reviewed the assistive technology systems, deficits in the system had been addressed, improvements were noted and an action plan was in place to address the remaining deficits by August 2015. Falls risk assessments were completed in accordance with the guidance.

Five recommendations which relate to the key question "**Is Care Effective**?" were made following the inspection undertaken on 22 & 23 January 2015.

These recommendations concerned an audit of training records; the completion of assessment and care documentation; the completion of specific assessments in relation to pressure ulcer risk assessments (Braden scale) and Malnutrition Universal Screening Tool (MUST) and the use of restrictive practices and blanket restrictions.

The inspector noted that four recommendations had been fully implemented. The ward manager had audited staff training and a mechanism was in place to monitor staff training. The inspector noted that all staff had received up to date mandatory training. Assessment and care documentation including Braden scales and MUST had been completed in accordance with the guidance and policy and procedure.

However, despite assurances from the Trust, one recommendation had not been fully implemented. Although the ward had made some progress in the use of restrictive practices and blanket restrictions with the development of restrictive care plans, these were not individualised and did not include a clear rationale that reflected why each patient required the level of restriction.

There were no recommendations which relate to the key question "**Is Care Compassionate**?" made following the inspection undertaken on 22 & 23 January 2015

5.0 Ward Environment

"A physical environment that is fit for purpose delivering a relaxed, comfortable, safe and predictable environment is essential to patient recovery and can be fostered through physical surroundings." Do the right thing: How to judge a good ward. (Ten standards for adult-in-patient mental health care RCPSYCH June 2011)

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

Summary

The interior of the ward was designed to promote a dementia friendly environment. Signage around the ward was of a good size and easily seen. The ward was spacious, well maintained, clean and clutter friendly. The environment enabled patients to mobilise freely around the ward. There was ample natural light and a pleasant, light odour from an aromatherapy diffuser. Low level appropriate music was played in the ward. All bedrooms were single and had ensuite facilities.

There was a good mechanism in place for patient and relative feedback. However the information displayed was not up to date.

On the day of the inspection there was adequate staffing to meet the needs of the patients. Staff were observed to be available in the patients communal area at all times. Staff were considerate to patients needs, offered constant reassurance when patients who were confused and disorientated and were skilled at supporting and reassuring patients who were distressed.

Exit from the ward is controlled by a swipe system. Information was displayed in relation to Deprivation of Liberty guidance and included in the ward welcome pack.

Although there was a good range of available activities displayed on the ward, there were no activities available on the ward on the day of the inspection. Ward staff, patients and relatives highlighted the lack of activities as a concern.

Seating around the ward promoted social interaction, however there were quiet areas for patients to retreat to. A dining room was available for patients to eat together and ample seating for staff or relatives to assist at mealtimes.

A ward specific ligature risk assessment had been completed. All of the beds in the ward were profiling beds. There was no individualised ligature risk assessment in place or a subsequent risk management plan to address any identified risks related to the use of profiling beds. A recommendation has been made in relation to this.

The inspector identified other areas which should be reviewed by the ward manager to improve standards on the ward in accordance with good practice guidance. These include:

- The ward welcome pack should include details to guide visitors on what to do if they observed a potential child protection concern.
- Ensure that patient and relative feedback displays are up to date.

The detailed findings from the ward environment observation are included in Appendix 3.

6.0 Observation Session

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.

The inspector 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.

Summary

On the day of the inspection the inspector observed interactions between staff and patients/visitors. Eight interactions were noted in this time period. The outcomes of these interactions were as follows:

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

Staff were observed to be attentive to patient's needs. Staff were observed responding promptly to any queries raised by patients and relatives. All interactions were observed as positive. Staff were kind and compassionate, treated patients with dignity and respect and were observed to be considerate to relatives. Staff demonstrated their knowledge and skills in supporting patients with dementia and were noted to be skilled in supporting patients who were distressed and / or confused. Staff were observed to be actively engaging with patients, offered choices and sought consent before care tasks.

The detailed findings from the observation session are included in Appendix 4

7.0 Patient Experience Interviews

Two patients agreed to meet with the lay assessor and complete a questionnaire regarding their care, treatment and experience as a patient.

Two relatives agreed to meet with the inspector to talk about the care and treatment on the ward.

Both patients stated they felt safe and secure on the ward. Relatives also indicated that care was safe. Relatives were aware of both their and their family members rights.

Patients and relatives gave a mixed response to questions asked in relation to effective care.

Overall relatives stated that their family member was well cared for. Patient responses also indicated that they felt well cared for. However, relatives raised a number of concerns. One relative stated that although they were given the opportunity to raise concerns or make requests in relation to their family members care and treatment, they were not always informed of the outcomes. One relative commented that communication could be improved as they stated "we get *the big weekly phone call to ask if there is anything we want raised at the weekly meeting and there is no feedback".* The relative also stated "*sometimes it's more a case of asking*" as staff do not actively tell them how their family member is progressing. This was addressed with the ward manager and at the conclusion of the inspection. One relative stated communication was good and they were fully involved in any decisions about their family members care and treatment.
Overall patients and relatives expressed their dissatisfaction about the lack of therapeutic and recreational activities on the ward. One patient stated there wasn't much happening to keep them busy and they were *"bored".* One relative stated "*activities would be helpful*" and one relative stated that *"individualised activities would be beneficial".*

Both patients and relatives indicated that care was compassionate on the ward. Patients and relatives stated staff treated them with dignity and respect. Both patients and relatives stated that staff take time to listen to them and are attentive to their needs.

Relatives quotes:

"Care here is pretty exceptional and there is a good skill mix"
"Communication has been first class"
"Staff are good and kind and look after my relative very well"
"I don't think there is anywhere better that my relative could be"
"We think our relative is well looked after"

The lay assessor concluded that they would be happy for any of their relatives in the same circumstance to be cared for on this ward.

The detailed findings are included in Appendix 2

9.0 Next Steps

A Quality Improvement Plan (QIP) which details the areas identified for improvement has been sent to the ward. The Trust, in conjunction with ward

staff, must complete the QIP detailing the actions to be taken to address the areas identified and return the QIP to RQIA by 17 August 2015.

The lead inspector will review the QIP. When the lead inspector is satisfied with actions detailed in the QIP it will be published alongside the inspection report on the RQIA website.

The progress made by the ward in implementing the agreed actions will be evaluated at a future inspection.

Appendix 1 – Follow up on Previous Recommendations
Appendix 2 – Patient Experience Interview
This document can be made available on request
Appendix 3 – Ward Environment Observation
This document can be made available on request
Appendix 4 – QUIS
This document can be made available on request
Appendix 5 – Quality Improvement Plan

Appendix 1

Follow-up on recommendations made following the unannounced inspection on 22 and 23 January 2015

No.	Reference.	Recommendation	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	Section 5.3.3(d)	It is recommended the Ward Manager audits training records to identify gaps in knowledge and skills and ensure attendance at required training. (3)	The inspector reviewed the outcomes from the audit and the training records for 27 staff working on the ward and noted the following: A visual aid board was available in the staff room and ward managers office. The board detailed staff members name; mandatory training; date training completed and training renewal date; Staff training was audited by the ward manager on a monthly basis; A training matrix was available; All staff had received up to date mandatory training.	Fully met
2	Section 5.3.1(a)	It is recommended that the ward manager ensures that all assessment and care documentation is completed in accordance with Trust and clinical standards. (2)	The inspector reviewed the audit of patient records. The audit was completed every month and was noted to be robust, detailed any deficits in care documentation, included an action plan and a timeline for addressing the deficits. The audit was signed by the auditor and the responsible nurse. The inspector reviewed care documentation in relation to four patients. Both medical and nursing assessments and care documentation had been completed fully and in accordance with trust and clinical standards.	Fully met
3.	Section 5.3.1 (a)	It is recommended that the ward's assistive technology devices are reviewed and any deficits or shortfalls are addressed. (2)	The inspector reviewed documentation and an email paper trail and noted that the wards assistive technology devices had been reviewed. The review addressed any deficits and shortfalls. The inspector observed the ward assistive technology system and noted improvements had been made in the falls systems. Wireless falls	Fully met

			systems were available in six bedrooms. Further plans were confirmed to address deficits by August 2015.	
4	Section 5.3.1.(a)	It is recommended that the ward manager ensures that the falls risk care pathway is implemented as required. (1)	The inspector noted that the falls risk assessment were included in the monthly patient documentation audit. The inspector reviewed the falls risk assessments in relation to four patients and noted that these had been completed and reviewed in accordance with the falls risk care pathway. A care plan was completed when a patient was assessed as a high risk of falling. Assessments and care plans were also reviewed following fall. Care plans were noted to be comprehensive in addressing the risks.	Fully met
5	Section 5.3.1.(a)	It is recommended that the Trust reviews the ward's procedure in relation to the implementation of the ulcer risk assessment (Braden scale) and ensures that the scale is implemented in accordance to each patients assessed need. (1)	The inspector noted that the pressure ulcer risk assessment (Braden scale) was included in the monthly audit of patient documentation. The inspector reviewed the pressure ulcer risk assessment in relation to four patients. Pressure ulcer risk assessments were completed fully and in accordance with the guidance. Patients who were identified as a moderate to high risk of pressure ulcers had a care plan in place to manage the risk. The inspector noted that the risk assessments for the four patients were reviewed weekly.	Fully met
6.	Section 5.3.1.(a)	It is recommended that the ward manager ensures that the malnutrition universal screening tool (MUST) assessment is implemented in accordance to the required standard. (1)	The inspector noted that the malnutrition universal screening tool (MUST) assessment was included in the monthly audit of patient documentation. The inspector reviewed MUST assessments in relation to four patients. Must assessments were completed on admission and reviewed weekly in accordance with the guidance.	Fully met

7.	Section 5.3.1.(a)	It is recommended that all restrictive practices on the ward and blanket restrictions in response to individual risk are reviewed to insure that risk management strategies are based on individual assessment. (1)	The inspector noted that information in relation to deprivation of liberty was displayed on the ward and included in the ward welcome pack. This information stated "The main doors are locked. Liberty is restricted. This is in the best interests of the patients who may lack capacity and require a safe environment." The ward had made some improvements and had developed restrictive care plans. The inspector noted these were not individualised or a clear rationale recorded to reflect why each patient requires this level of restriction in three out of the four sets of care documentation reviewed. This recommendation will be restated for a second time.	Not met

Quality Improvement Plan

Unannounced Inspection

Downe Dementia, Downe Hospital

22 June 2015

The areas where the service needs to improve, as identified during this inspection visit, are detailed in the inspection report and Quality Improvement Plan.

The specific actions set out in the Quality Improvement Plan were discussed with the ward manager, assistant director, the operations manager, and ward staff on the day of the inspection visit.

It is the responsibility of the Trust to ensure that all requirements and recommendations contained within the Quality Improvement Plan are addressed within the specified timescales.

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
Is Care Safe?					
1	Section 5.3.1.(a)	It is recommended that all restrictive practices on the ward and blanket restrictions in response to individual risk are reviewed to insure that risk management strategies are based on individual assessment.	2	Immediate and on-going	The restrictive practice care-plan has been updated to include the rationale as to why restrictions are in place for each individual patient & will be reviewed daily in patient progress notes. Guidance has been provided for staff to refer to when prescribing careplans. The restrictive practice care plan will be included in the monthly documentation audit to ensure a robust monitoring mechanism is in place to address any deficits in care plan documentation
2	5.3.1 (a)	It is recommended that the ward manager ensures that each patient has an individualised ligature risk assessment completed for use of the profiling beds. This should include a subsequent risk management plan to address any identified risks, in accordance with the	1	Immediate and on-going	As above & will include risk assessment & rationale regarding the use of profiling beds for each individual patient. All hand controls on profiling beds had already been removed prior to the inspection on June 22nd 2015 to remove the potential ligature risk of same

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
		Northern Ireland Adverse Incident Centre (NIAIC) – EFA/2010/006 safety alert self-harm associated with profiling beds.			
Is Care Effective?					
3	5.3.3 (d)	It is recommended that the Trust ensures that occupational therapy services are available Monday to Friday on the ward.	1	30 December 2015	The Occupational Therapy team for MHSOP is relatively small & its ability to deliver the expected range of services within Down Dementia Ward has been impacted due to long term sickness and a maternity leave, for which the provision of temporary cover has not been possible. There has been a delay in replacing a vacant band 6 OT postwhich is now in the process of being filled. It is anticipated that the full compliment of OT staff for the ward will be available within the very near future
4	5.3.3 (d)	It is recommended that the trust review the availability of daily therapeutic and recreational activities for patients on the ward.	1	30 December 2015	There will be specific focus to provide personalised activities & opportunities for interaction & occupational participation for each patient which is key to that individual's identity.

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
		Following this review it is recommended that a mechanism is put in place to ensure patients have access to a range of individualised and group therapeutic and recreational activities throughout their admission.			This will be led by the Specialist OT who will complete a Pool Activity Level & Interest checklist for each patient. Guidance & information will then be shared with all staff & relatives. Completed Adapted Activities reports will provide specific guidance for all staff. Information will be provided in the patient's room detailing key interests & activities that are meaningful to them to enable participation by family & carers. In line with NICE Guideline PH16 there will be regular group &/or individual sessions to encourage patients to identify, construct, rehearse & carry out daily routines & activities that help maintain or improve health & wellbeing. There will be Mon – Fri therapeutic activities provided on the ward by the OT Assistant. Training workshops will be provided by the OT staff to all ward staff to support the cultural change that all interactions with patients can be of value & meaningful to each patient. The "Living Well in

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
					Care Homes" toolkit resourse pack, developed by the College of Occupational Therapists will be utilised as this is relevant within the dementia ward setting. OT staff will support nursing staff to co-facilitate recreational & therapeutic sessions to improve staff confidence & competence following the workshops. This will assist to enable ward staff to provide access to activities in the evenings & weekends The Specialist OT & OT assistant will provide information & support to family & carers to help them to engage in activities that are meaningful & purposeful specific to their family member.

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
Is Care Compassionate?					
		No recommendations were made			

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

NAME OF WARD MANAGER COMPLETING QIP	Paula Thompson
NAME OF CHIEF EXECUTIVE / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Brenda Arthurs Assistant Director Primary Care & Nursing

Inspector assessment of returned QIP		**Yes**	**No**	**Inspector**	**Date**
A.	Quality Improvement Plan response assessed by inspector as acceptable	✓		Wendy McGregor	**3 August 2015**
B.	Further information requested from provider				