Mental Health and Learning Disability Inpatient Inspection Report
2 November 2016

Ward 15 Shimna House

Addiction Service
Downshire Hospital
Ardglass Road
Downpatrick
BT30 6RA

Tel No: 028 44513922

Inspector: Cairn Magill

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

Ward 15 Shimna House is a fourteen bed, mixed gender inpatient facility providing services to adults with alcohol and/or drug dependence. The ward provides detox, stabilisation and rehabilitation to patients through a range of clinical, low level psychological, occupational, individual and group recovery based interventions with support from Alcohol Anonymous (AA) and Narcotics Anonymous (NA).

The ward's multidisciplinary team consist of nursing staff and health care assistants, consultant psychiatrists, a senior house officer and an occupational therapist.
The ward is further supported by peer advocates, community addictions teams and a referral system to social work and other allied health professionals if required.

On the day of inspection there were ten patients on the ward. There were no patients detained in accordance with the Mental Health (Northern Ireland) Order 1986.

The ward is open and patients can independently leave the ward. The ward was warm, bright, airy and welcoming. The ward was clutter free, clean and fresh smelling. There were single and twin rooms and twin rooms were gender specific. There was a separate dining room and day room with additional seating in the glass fronted foyer.

A newly appointed deputy ward manager was in charge on the day of the inspection.

3.0 Service Details

Responsible person: Mr. Hugh McCaughey	**Position:** Chief Executive
Ward manager:	Paul Watterson
Person in charge at the time of inspection: Tricia Davies, Deputy Ward Manager	

4.0 Inspection Summary

An unannounced inspection took place on 2 November 2016.

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.

We assessed if Ward 15 was delivering, safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in relation to the pre-admission assessment. Patients were very well informed prior to admission and agreed to and signed the pre-admission treatment agreement. Upon admission patients were provided with a comprehensive workbook which provided additional information for them, informing them about what they can expect from the treatment programme and how they can inform their friends, family and carers to support them. There was good involvement with patients in the development of their care and treatment plans. There was also good practice in relation to the facilitation of community addiction support groups to support recovery. There was adequate staffing levels and protected time for named nurses to have one to one time with patients.

Areas requiring improvement were identified in relation to;

- Increasing the number of narcotic anonymous support groups on the ward. The inspector was made aware of the ongoing efforts to increase the number of narcotics anonymous meetings on the ward to two evenings per week. This was as a result of patient feedback.

- Patients access to a quiet room. The ward does not have a quiet room where patients use currently. However the trust is in the process of re-designating a room upstairs for patients to use as a quiet room.

- More comfortable seats for patients to use during therapy sessions. Patients stated that they would like more comfortable seats as they are sitting for a large part of the day meditating, participating in therapy groups or relaxing.

- Record keeping. There was difficulty identifying who was responsible to follow up agreed actions discussed at the weekly Team Assessment Meetings (TAM). This issue is further identified in the section entitled Is Care Effective?

Patients said that staff were very approachable, friendly, and respectful and always sought consent and permission prior to any intervention. Patients were satisfied with the food and the cleanliness of the environment and the information provided to them. Patients also said that they liked how they were very involved in their care plans.

The addictions service manager and ward manager reported to the inspector that the service is currently reviewing its discharge process to move days of discharge from a Friday to a Monday. This is because community services and support are available for patients rather than continue with the weekend discharge when these services are not available.

Patients Stated:

“I haven’t been in here before, I was given information before I came in and as soon as I came in I was put at ease straight away”.

“The workbook is brilliant. It tells you how to behave in groups, how to write letters and there is even a family pack which I could give to my mum and dad”.

“We have everything we need. Everything works well”.

“The food is actually very nice, there is a good choice”.

“Staff are always available for one to ones and they are very responsive”.

“We are given input to our care plans and there were a couple of things I didn’t agree with but we worked through it”.

“They treat everyone as an individual, they know everything about you and know what questions to ask to make you think and reflect”.

“There should be more meetings from Narcotics Anonymous (NA) on the ward”.

“I previously attended XXX (a private clinic) at a huge weekly cost. The care and treatment here far exceeds that which I got there”.

The findings of this report will provide the service with the necessary information to enhance practice and service user experience.

4.1 Inspection Outcome

Total number of areas for improvement	Four

Findings of the inspection were discussed with the ward manager, members of the multi-disciplinary team, ward staff and senior management as part of the inspection process and can be found in the main body of the report.

Escalation action did not result from the findings of this inspection.

The escalation policies and procedures are available on the RQIA website.
https://www.rqia.org.uk/who-we-are/corporate-documents-(1)/rqia-policies-and-procedures/

5.0 How we Inspect

Prior to inspection we review a range of information relevant to the service. This included the following records;

- The operational policy or statement of purpose for the ward,
- Incidents and accidents,
- Safeguarding vulnerable adults,
- 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.

During the inspection the inspector met with three service users, six ward staff and one visiting professional. There were no carers or visitors available at the time of the inspection.

The following records were examined during the inspection:

- Care documentation in relation to three patients,
- Staff rota,
- Training records,
- Patient treatment agreement,
- Patient work book,
- Information given to family members and carers,
- Fire and evacuation policy,
- Maintenance checks.

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

We reviewed the areas for improvements/ recommendations/ made at the last inspection (if required). An assessment of compliance was recorded as met.

The preliminary findings of the inspection were discussed at feedback to the service at the conclusion of the inspection.

6.0 The Inspection

6.1 Review of Recommendations from the Most Recent Inspection dated 2 June 2016

The most recent inspection of Ward 15 Shimna House was an unannounced inspection. The completed Quality Improvement Plan (QIP) was returned and approved by the responsible inspector. This QIP was validated by the inspector during this inspection.

6.2 Review of Recommendations from Last Inspection dated 2 June 2015

Areas for Improvement		**Validation of Compliance**
Number/Area 1 **Ref**: Standard 5.3.1 (a) **Stated:** First Time	It is recommended that the ward manager reviews the blanket restriction of locked shower areas on the ward. Any blanket or individualised restrictions should be clearly reflected in individual patient care plans.	**Met**
	Action taken as confirmed during the inspection: Inspector confirmed that on the day of inspection all shower doors were open.	

7.0 Review of Findings

7.1 Is Care Safe?

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

Areas of Good Practice

There is a comprehensive pre-admission assessment to ensure patients who are at significant risk of self -harm are not admitted to Ward 15.

Patients reported that they were involved and prepared prior to their admission to Ward 15. Upon admission and thereafter patients stated that they are very actively involved in designing and managing their individual personal safety plans.

Inspector observed patient involvement in their safety and risk management plans in care documentation.

Patients stated that they are encouraged to reflect about their vulnerabilities, social networks, situations and environments that will increase their risk of relapse and are encouraged to devise a plan to minimise the opportunities and triggers that could contribute to a relapse.

Ward 15 operate daily huddle meetings and weekly team assessment meetings (TAM) where all members of the multidisciplinary team contribute to the personal well-being plans of each patient.

The ward ligature risk assessment was completed and appropriate action plans were in place.

Staff who met with the inspector were aware of how to and who to raise concerns about environmental safety, patient safety or the level of care provided to patients.

All staff who met with the inspector stated they were never required to work beyond their role, experience and training.

Patients stated they know how to make a complaint and the process is explained in the patient information booklet.

Areas for Improvement

Not all staff had personal safety alarms.

Number of areas for improvement	One

7.2 Is Care Effective?

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

Areas of Good Practice

Upon admission and on an on-going basis patient's needs are comprehensively assessed and treatment plans are amended as required.

Patients reported to the inspector that they are fully involved in the co-production of their care plans which are person centred and recovery focused.

The inspector reviewed care documentation and spoke with the senior house officer and nursing staff that were all aware of the standard treatment options and evidence based treatment and practice for the various addictions.

Patients report staff take the time to explain to them in full the proposed plan of treatment and options to ensure the patient can make an informed decision.

One patient stated that in addition to their addiction they had also had difficulties with eating and since their admission their appetite has improved greatly and they had increased their weight by ½ stone.

All staff and patients who met with the inspector were able to report that staff continued to monitor and evaluate the care and treatment offered to patients. Care documentation evidenced the close monitoring of the patient for physical signs and symptoms of withdrawal from their addiction and with medication prescribed to help with the withdrawal symptoms.

Prior to admission, patients sign the treatment programme agreement which explains home leave and when it is available to patients. The pre-admission contract also explains to patients the policy on the use of mobile phones.

Patients stated that the experience and support of the peer advocate was positive and that this enabled them to gain insight into their addiction and give them hope for their recovery.

Patients reported that a guided meditation session in the morning was a better option than having to do it individually.

Patients reported that the occupational therapist takes time to plan and structure their routine and that this was helpful to them.

Patients said they benefited from staff support and reminders about the importance of having a positive routine in their lives to prevent self- neglect and promote motivation.

Staff ensure they are available to patients for one to one time.

Areas for Improvement

The inspector reviewed the care documentation held on the electronic information system (Maxims) with the ward manager. There were records of the weekly team assessment meeting (TAM). Agreed actions and decisions were recorded in the TAM documentation but no specific staff member was identified to complete the action. The comment "All nursing staff" was placed against the action point. The inspector also noted that there was no easy means of accessing information on the Maxims system to evidence that any particular action point was followed up.

Ward staff highlighted the need for social work service within the ward to assist with timely and effective discharge planning.

Number of areas for improvement	Two

7.3 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.

Areas of Good Practice

All patients stated that staff treat them with dignity and respect and staff responded sensitively and compassionately to their emotional and or physical needs.

Patients are given information prior to their admission to Ward 15. This explains about the daily huddle meetings and Team Assessment Meetings (TAM). Information is also provided about the treatment and recovery programmes. Patients stated they valued this information in advance.

Patients are consulted on a daily basis about their specific care and treatment and are encouraged to make informed decisions on options available.

All patients who met with the inspector stated they were very satisfied with the care and treatment provided to them and with the way staff have treated them from admission.

Details of ward and peer advocates are posted in the ward and all patients stated that they benefited from the peer advocate's experience.

Areas for Improvement

No areas for improvement were identified during the inspection.

Number of areas for improvement	None

7.4 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 were aware of their roles and responsibilities and what actions they should take if they have a concern about safeguarding, child protection, escalation or whistleblowing.

The treatment programme is set at 25 days and this is mainly adhered to but is negotiable for those patients who request a weekday discharge to ensure appropriate community support is available.

The inspector reviewed the pre-admission information requested which contained minutes of staff meetings which evidenced that systems are in place to analyse risks, accidents, incidents SAIs, complaints and safeguarding.

The sharing of learning is evident and is a standing item on the staff team agenda.

All staff who met with the inspector reported good working relationships across the multi-disciplinary team.

There was evidence of regular audits and key performance indicators (KPIs) which feature as a standard item on the agenda for staff meetings.

Patients reported that there has been a marked improvement in pre-admission information provided to patients. Staff reported this improvement was as a result of patient feedback. In particular the Ward 15 workbook and patient information leaflet explains to families and carers how they can help the patient with their recovery and how the treatment / recovery plan works.

There are ongoing efforts to increase the number of Narcotics Anonymous meetings on the ward to two evenings per week. This was a result of patient feedback.

All staff who met with the inspector were aware of the organisational and management structure and knew were aware of lines of responsibilities.

Staff's mandatory training was up to date. The database clearly demonstrated which training required to be updated and this was highlighted prior to the date of expiry to assist in timely planning of training.

All staff had received up-to-date supervision.

The inspector reviewed the staff duty rota and noted that there has been no significant use of bank or agency staff. The staff team in Ward 15 appears to be well established and settled.

A new deputy manager was recently appointed following the ward being designated as a sub-regional Tier 4 Addiction Treatment unit.

Areas for Improvement

There were a number of policies which were out of date and which required a review. These included the Fire Safety Policy which was due review in June 2015 and Ward 15 operational policy which is currently in draft format.

Number of areas for improvement	One

8.0 Provider Compliance Plan

Areas for improvement identified during this inspection are detailed in the provider compliance plan. Details of the provider compliance plan were discussed at feedback, as part of the inspection process. The timescales commence from the date of inspection
The responsible person should note that failure to comply with the findings of this inspection may lead to further /escalation action being taken. It is the responsibility of the responsible person to ensure that all areas identified for improvement within the provider compliance plan are addressed within the specified timescales.

8.1 Areas for Improvement

This section outlines recommended actions, to address the areas for improvement identified, based quality care standards, MHO and relevant evidenced based practice.

8.2 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.

Provider Compliance Plan Ward 15	
Priority 1	
There are no priority one areas for improvement.	
Priority 2	
Area for Improvement No. 1 **Ref:** Standard 5.3.1.(f) **Stated:** First time **To be completed by:** 2 February 2017	**The responsible person must ensure the following findings are addressed:** All staff to be issued with personal safety alarms
	Response by responsible person detailing the actions taken: All multidisciplinary staff, including visiting professionals, are issued with a personal attack alarm when they report for duty. A protocol is in place where each member of staff signs a daily record that they have received a working alarm at the commencement of their duty and that they sign that alarm back in when they leave the building. Shimna House (Ward 15) has been given priority status in terms of having its own integral alarm system installed given its isolation and the complexity of the patients it provides services to. It is anticipated that the capital funding required will be available 16/17 and therefore, the work is planned to commence within the current financial year.
Area for Improvement No. 2 **Ref:** Standard 5.3.1.(f) **Stated:** First time **To be completed by:** 2 February 2017	**The responsible person must ensure the following findings are addressed:** Record keeping. Identifying person responsible for following up actions agreed at TAM and evidence of action taken in Maxims system.
	Response by responsible person detailing the actions taken: The multidisciplinary team, under the ward manager's leadership, have now implemented a system whereby an individual staff member is identified as being responsible for actions agreed at TAM meetings. The team will review the actions agreed at the following week's TAM in order to ensure that the action has been undertaken as planned and evidenced within the Maxims narrative. This is now subject to ongoing audit.

Area for Improvement No. 3 **Ref:** Standard **Stated:** First time **To be completed by:** 2 February 2017	**The responsible person must ensure the following findings are addressed:** Review and update of policies
	Response by responsible person detailing the actions taken: The Ward 15 operational policy is being updated in light of the service becoming one of three sub-regional addiction treatment units. The Regional policy is currently being finalised in keeping with agreed operational protocols between the other two sub-regional units. Once agreement is reached regionally, we can sign off the local draft. Fire policy: The Senior Manager for Addictions Services has contacted the author of the Fire Safety Policy to advise of the need to update this policy. The Trust Fire Officer has confirmed that the Policy in question has been reviewed, finalised and is currently awaiting endorsement by the Chief Executive.
Priority 3	
Area for Improvement No. 4 **Ref:** Standard 6.3.1(a) **Stated:** First time **To be completed by:** 2 May 2017	**The responsible person must ensure the following findings are addressed:** Social work service
	Response by responsible person detailing the actions taken: Where patients require the continuing input of Social Services, dedicated Additions Services Social Workers are liaised with directly and are invited to multidisciplinary meetings and reviews as they occur. The service recognises the need for a fully integrated multidisciplinary team to fully meet the complexity of needs that our patients present with. While each community team has at least one Social Worker within the team that liaise and contribute to their patient care while on the ward, having a dedicated ward based Social Worker would complement the team enormously. Last year we appointed an Occupational Therapist to the team and our main priority, if further funding becomes available, would be to appoint a dedicated Social Worker within the ward.

Name of person(s) completing the provider compliance plan	Noel Taggart		
Signature of person(s) completing the provider compliance plan		**Date completed**	
Name of responsible person approving the provider compliance plan			
Signature of responsible person approving the provider compliance plan		**Date approved**	
Name of RQIA inspector assessing response	Cairn Magill		
Signature of RQIA inspector assessing response	Cairn Magill	**Date approved**	29/12/2016