The Regulation and Quality Improvement Authority

Inspection Report

3 May 2023

Ward 15 Downshire Hospital

Type of service: Addictions
Address: Downshire Hospital,
Ardglass Road, Downpatrick,
BT30 6RA
Telephone number: 028 4451 3921

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation/Registered Provider: South Eastern Health and Social Care Trust (the Trust) **Responsible Individual(s):** Roisin Coulter Chief Executive	**Registered Manager:** Paul Watterson
Person in charge at the time of inspection: Tracey Greeves, Deputy Ward Sister	**Number of registered places:** 12
Categories of care: Addictions Service	**Number of patients accommodated in the ward on the day of this inspection:** 6
Brief description of the accommodation/how the service operates: Ward 15 (Downshire) is a regional inpatient addiction unit which can accommodate 12 patients. The service provides care and treatment to patients who have alcohol and/or drug addiction. A range of treatments including medical detoxification, and/or stabilisation for patients with complex drug and alcohol issues is provided. The average length of stay in the ward is three weeks. All patients agree to attend the ward for treatment and admissions are on a voluntary basis.	

2.0 Inspection summary

An unannounced inspection of Ward 15 took place on 3 May 2023 between 9am and 5pm. The inspection was completed by two care inspectors.

The inspection focused on ten key themes including, environment, incident management and adult safeguarding, staffing, physical health, restrictive practices, patient experience, governance, medication management, patient flow and mental health.

Care observed throughout the inspection was found to be effective and compassionate. Staff knew the patients well and were responsive to their individual needs.

Four areas for improvement (AFI) included in the Quality Improvement Plan (QIP) from the most recent inspection of Ward 15 on 12 April 2018 were assessed. Two AFI were assessed met, two were not met and will be stated for a second time and three new AFI were identified.

Although AFI were identified, the outcome of this inspection was positive. Areas of good practice were noted in relation to patient experience, patient flow, physical and mental health.

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how they were performing at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

We reviewed records in relation to patients' planned care and treatment, and observed how they spent their day. Experiences and views were gathered from staff and patients.

4.0 What people told us about the service

Posters and leaflets were placed throughout the ward inviting staff and patients to speak with inspectors and feedback on their views and experiences.

We spoke with a number of patients and staff, all of whom spoke positively about the service. We received six patient questionnaires during the inspection, all of which reflected the patients were highly satisfied with the care and treatment they received. Patient experience is discussed further in Section 5.2.6.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

The last inspection of Ward 15 was undertaken on the 12 April 2018 by a care inspector.

<table>
<tr><th colspan="3">Areas for improvement from the last inspection on 12 April 2018</th></tr>
<tr><th colspan="2">The responsible person must ensure the following findings are addressed:</th><th>Validation of compliance</th></tr>
<tr><td rowspan="2">Area for Improvement No. 1

Ref: 6.3.1(a)

Stated: Second Time</td><td>Social Work Service</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
The service has employed a full time permanent social worker who is part of the multi-disciplinary team.

This area for improvement has been met.</td></tr>
<tr><td rowspan="2">Area for Improvement No. 2

Ref: 5.3.1 (e)

Stated: First Time</td><td>Action points noted in the fire risk assessment were not actioned.</td><td rowspan="2">Not met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
The most recent fire risk assessment was reviewed and identified that actions had not been completed. Further detail is provided in Section 5.2.1

This area for improvement has not been met and has been stated for a second time.</td></tr>
<tr><td rowspan="2">Area for Improvement No. 3

Ref: 5.3.1

Stated: First Time</td><td>Staff meetings are not happening regularly</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
Evidence that staff meetings were held regularly was provided.

This area for improvement has been met.</td></tr>
</table>

Area for Improvement No. 4 **Ref:** 5.3.3 **Stated:** First Time	Supervision was not occurring as frequently as was stipulated in the South Eastern Trust supervision policy.	**Not met**
	Action taken as confirmed during the inspection: There was evidence that some supervisions had taken place, however the matrix recording the frequency of supervisions was not up to date and it could not be determined if the frequency of supervision was in line with Trust policy. This area for improvement has not been met and has been stated for a second time.	

5.2 Inspection findings

5.2.1 Environment

The ward was clean and furnished appropriately to meet the patients' needs. Although the building is dated, the ward had a warm and welcoming atmosphere. Patients had access to a garden area and tennis court.

The internal structure of the building requires attention to ensure that it is conducive to a therapeutic environment. A schedule of remedial works has been developed; however, there has been limited progress. The Trust should review the timescales in relation to the refurbishment to improve the therapeutic space for patients.

A corridor runs the length of both floors which provides access to all other rooms. Patients could relax and engage with others in a bright and well-presented lounge. Patients could make snacks and drinks in the kitchen. A room used by patients for quiet space was locked and patients had to request access from nursing staff. The Trust should risk assess the need to lock this room.

Patients had their own bedrooms, one of which had an en-suite shower room. Two bedrooms could not be easily observed by staff due to their location, which may be a risk if patients require assistance. These rooms were not in use at the time of inspection; however, the Trust should review the location of these rooms and risk assess their use in relation to patient safety.

Communal single sex bathrooms and showers are located on the ground floor. The bathroom facilities would benefit from refurbishment / modernisation.

Patients and their families could use a family visiting room on the first floor which had books, toys, and games for younger children visiting.

Information boards provided details of the staff team, the staff that are on duty, and the times of group therapy sessions that patients were required to attend. Further information was available to patients at the entrance to the ward. This included support for alcohol and drug addiction, health promotion, and advocacy support.

The most recent Fire Risk Assessment (FRA), dated September 2022, and Fire Policy were examined. It was noted that not all actions identified in the FRA had been completed. The Trust must ensure that all actions identified in the FRA are actioned, within the stated timeframes, to ensure patient and staff safety.

Fire safety checks were completed and recorded in accordance with the Trust's Fire Safety Policy. A number of fire doors were observed to be wedged open. This was brought to the attention of ward management and actioned immediately.

A Ligature Risk Assessment (LRA) was first completed in July 2016 with the most recent annual review completed in March 2021. A number of risks that remained after control measures had been implemented had been escalated to senior management which resulted in a list of works proposed for 2021/22. At the time of this inspection these works had not been completed. The Trust should review the LRA and ensure remedial works are completed within revised timeframes.

An area for improvement has been identified in relation to ligature risk assessment and the environment. The area for improvement in relation to the FRA has been stated for a second time.

5.2.2 Adult Safeguarding and incident management

Adult Safeguarding (ASG) is the term used for activities which prevent harm from taking place and which protects adults at risk where harm has occurred or is likely to occur without intervention.

Information pertaining to the ASG policy and procedure was displayed in staff areas. Staff were knowledgeable in relation to ASG Regional Policy. There was a robust system in place that included oversight by the safeguarding champion to ensure compliance with ASG policies and procedures. There were no ward based adult safeguarding investigations open at the time of the inspection.

There were 24 incident reports (Datix) recorded for the last 12 months. The majority of incidents were graded consistently.

Incident reports were completed to a good standard and there is a system in place to review incidents, and share learning, by senior management. A number of incidents of verbal and physical aggression, by patients towards staff, were recorded. The Trust are reminded when reviewing incidents that potential risks to staff and patients should be fully assessed and appropriate action taken to mitigate those risks. The Trust should also consider any necessary action required to provide additional support to patients and staff where needed.

5.2.3 Staffing

Staffing levels on the ward were determined using the Telford model, which is a tool to assist staff in defining staffing levels based on patient acuity. The arrangements for staffing were reviewed and staffing levels were evidenced through discussion with staff, analysis of staff duty rotas, and observation of staff on shift.

The ward operates a biopsychosocial model of care. This holistic approach takes into account the physical, psychological, and social factors of addiction and promotes an integrated approach to treatment by the multi-disciplinary team (MDT). The MDT consists of a consultant psychiatrist, medical staff, social worker, occupational therapist (OT) and nursing staff. A health development specialist in alcohol and drugs supports the ward one day a week.

On the day of inspection, Ward 15 was operating at a reduced patient capacity due to reduced medical cover. The staffing compliment was adequate to meet the patients' needs. Staff raised concerns about safe staffing levels should the ward return to full capacity. The Trust must consider the safe staffing levels required when the ward is operating at full capacity, and also take into consideration the potential for incidents to occur, and staff reductions during breaks.

Patient and staff safety may be compromised due to the layout, location and facilities available on the ward. Should staff require assistance to manage an incident, response times may be delayed due to needing to telephone other wards directly. This issue would be most acute at night due to a limited number of staff. The Trust should complete a comprehensive risk assessment regarding the response to serious incidents to ensure the safety of patients and staff at all times.

The staff training matrix was reviewed for mandatory training and e-learning. The majority of staff were compliant with training requirements and there was management oversight to ensure staff who were in need of updates were identified in a timely manner.

5.2.4 Physical Health

Patients physical health records were reviewed. Records reflected that patient's physical health needs were met. Physical health checks were completed by medical staff with evidence of ongoing referral to medical specialists as required. Access to a dietician, diabetes nurse specialist, and speech and language therapists can be made by referral. Patients could access smoking cessation support if requested.

Patients completing detoxification during their care and treatment have the potential to require additional physical health support. Ward 15 is not equipped to deliver this level of acute care, therefore, any patient who experiences a physical health need that cannot be met in the ward would be transferred to an appropriate hospital for treatment.

5.2.5 Restrictive Practice

There were no restrictive practices on Ward 15. All patients are admitted on a voluntary basis. Patients are required to sign the pre admission treatment agreement and agree to follow the 'House Rules' as part of their treatment programme. This includes compulsory attendance at group therapies.

The ward is open and patients can independently leave the ward. Patients can avail of time outside, in the hospital grounds, when out on group therapy sessions which are facilitated by staff.

5.2.6 Patient Experience

Posters and patient leaflets were placed throughout the ward inviting patients, and staff, to approach the inspection team to express their views and experiences. We spoke with patients and all six patients completed a patient questionnaire.

Patient questionnaire responses were all very positive, with all patients scoring the four key themes; safe, compassionate, effective, and well led as 'very satisfied'. Patients spoke positively about their care and treatment and stated they felt involved in decisions and were listened to. Staff were described by patients as helpful, approachable, and sincere. All patients knew who their key worker was and reported they met with them regularly throughout the course of their treatment.

Patients and staff described a three-week programme of care. The three weeks are structured and take into consideration input from family and friends and plans for discharge on the final week included a 'sober living plan'.

The mealtime experience was reviewed. A wide variety of food options were available, all of which appeared appetising. There was a relaxed atmosphere through lunch and staff were available should patients require assistance.

Visiting is restricted and all items brought in by visitors are checked. Patients do not have access to their mobile phones; however, they can access a public telephone, located in a private space, should they wish to contact friends or relatives. Patients are asked to keep visiting to a minimum in a bid to limit disruption during group therapy sessions.

Patients are encouraged to complete a client satisfaction questionnaire and to make suggestions for improvement. The data is published annually and was displayed in the ward. It evidenced a high level of satisfaction and it was positive to note the ward manager was arranging patient feedback meetings to take forward any areas for improvement. The Trust should consider reviewing and publishing the data more frequently.

There is a weekly patient forum where patients can give their opinion and suggest improvements regarding their care and treatment. The ward also records the number of compliments received. The Trust should consider displaying compliments, ensuring confidentiality is maintained, as these could be motivational for patients commencing treatment.

The ward is supported by peer volunteers who have a lived experience of substance misuse and recovery. The peer volunteers give talks about their journey and experience, and are a source of encouragement and support to the patients. This practice is commended.

5.2.7 Governance

We assessed the governance arrangements through the examination of documentation and discussions with the ward manager and deputy manager.

An operational policy, reflecting the aims and purpose of ward was available for review. This document had not been signed or dated by the author. This Trust should ensure the operational policy is signed and dated.

Review of staff meeting minutes evidenced that these were taking place regularly and a standard agenda was being used.

One complaint had been received and managed appropriately in accordance with Trust policy and procedure.

Staff reported senior management visited the ward regularly; however, there were no records to evidence this. The Trust should put in place arrangements for the recording of senior management visits to wards, to include the purpose of the visit and the findings. Any actions arising from these visits should also be detailed. An area for improvement was identified.

The ward manager attends weekly regional meetings with other managers of addiction services of both inpatient and community services. This collaborative approach enables patient risks to be discussed and prioritisation for treatment agreed. This has a positive impact on outcomes for patients.

5.2.8 Patient Flow

There were six patients in the ward at the time of the inspection. Twenty patients were on the waiting list, all of whom had a planned admission date. The average waiting time was between four to six weeks. There were no delayed discharges.

The ward manager attends a weekly meeting to discuss admissions, discharges, and patients preparing to be admitted. This meeting is attended by various members of the MDT and professionals from community services involved in the patients' care. Discussions explore in detail the patients on the waiting list, patients who have been given a planned admission date and the patients currently on the ward and the progress they are achieving.

There was evidence of pre admission assessments completed for patients. Patients are admitted for a three-week treatment programme which is supported by community groups, Alcoholics Anonymous (AA), and Narcotics Anonymous (NA). Patients are encouraged to attend the weekly MDT meeting where discharge arrangements are discussed. The social worker supports patients to re-engage with families, and to secure suitable accommodation in preparation for discharge if required. Throughout the treatment programme the ward social worker supports visits from families, including children, and has produced a leaflet on 'How to talk to your children about your addiction'.

5.2.9 Medicines Management

Medicines were stored in the treatment room; this room had been relocated since the last inspection and was a now a more suitable and appropriate facility. The room was clean, well-organised, and medications were stored appropriately, including those that required refrigeration.

The use of pro re nata (PRN) medication, which is medication that is prescribed on an as and when necessary basis, was reviewed. PRN usage for all patients was minimal and was discussed at the weekly MDT meeting.

Medicines and oxygen for emergency use were checked and found to be in date. The ward had a system in place to identify when emergency medicines were due to expire.

Controlled drugs were safely and securely stored, with reconciliation checks being completed at shift handovers. A controlled drug audit is conducted quarterly by the pharmacist. This was last completed on the 28 April 2023 and evidenced safe management of controlled drugs.

5.2.10 Mental Health

During the admission process patients are assessed by medical staff, which includes an assessment of their mental state at the point of admission.

Where concerns regarding a patient's mental health are identified they will be assessed and if necessary transferred to a more appropriate setting. Patients are required to agree to a pre admission treatment agreement and 'house rules'. These include compulsory attendance at AA and NA meetings and random drug/ alcohol screening. Protocols to assess and monitor patients in acute withdrawal known as "withdrawal scales" are used for alcohol and opiate withdrawal. This supports clinicians in decision making regarding the patient's treatment.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006).

	Standards
Total number of Areas for Improvement	5

The total number of areas for improvement includes two that have been stated for a second time and three stated for a first time.

Areas for improvement and details of the Quality Improvement Plan were discussed with deputy ward sister, as part of the inspection process. The timescales for completion commence from the date of inspection.

<table>
<tr><th colspan="2">Quality Improvement Plan</th></tr>
<tr><td colspan="2">Action required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006)</td></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Standard 5.1
Criteria:5.3.1

Stated: Second time

To be completed by:
31 July 2023</td><td>The South Eastern Health and Social Care Trust must ensure that action points noted in the fire risk assessment are actioned within the specified timescales.

Ref: 5.2.1</td></tr>
<tr><td>Response by registered person detailing the actions taken:
A review of the Ward Fire Risk Assessment (13th September 2022), was completed by the Ward Manager on 26 June 2023. All action points have been completed as outlined in the report. In addition to this, to ensure continued compliance, the action points outlined will be reviewed by ward management at monthly staff meetings and this has been added as a standing agenda item.</td></tr>
<tr><td rowspan="2">Area for improvement 2

Ref: Standard 4.1
Criteria 4.3

Stated: Second time

To be completed by:
31 August 2023</td><td>The South Eastern Health and Social Care Trust must ensure that supervision is completed as stipulated in the Trust supervision policy.</td></tr>
<tr><td>Response by registered person detailing the actions taken:
Supervision is now delivered in line with Trust Policy on an ongoing basis and compliance levels are reviewed at Ward staff meetings as a standing agenda item to ensure ongoing and accurate recording. Managerial supervision and clinical supervision is provided for all staff.</td></tr>
<tr><td rowspan="2">Area for improvement 3

Ref: Standard 5.1 Criteria: 5.3.1

Stated: First time

To be completed by:
31 July 2023</td><td>The South Eastern Health and Social Care Trust must ensure:
• The ligature risk assessment is reviewed and actions are completed within agreed timescales.
• Environmental remedial works proposed are agreed and completed within suitable and realistic timescales.

Ref: 5.2.1</td></tr>
<tr><td>Response by registered person detailing the actions taken:
The Ward Ligature Risk Assessment has been reviewed by the Management Team.

The environmental remedial works list has been reviewed by the Service Manager, in conjunction with the Estates</td></tr>
</table>

	Department and these works will be completed in this financial year. SET have also commissioned and completed a business case for a total re-furbishment of the current Shimna House facility. The Estates Department has drawn up plans for a proposed remodelling of the current building to enable the delivery of Addictions Inpatient care in a modern, safe and user friendly fascility. This programme of works requires considerable investment and has been outlined on a list of priority capital projects, awaiting the necessary funding allocation.
Area for improvement 4 **Ref:** Standard 5.1 Criteria 5.3.1 **Stated:** First time **To be completed by:** 31 July 2023	The South Eastern Health and Social Care Trust must complete a comprehensive risk assessment regarding the response to serious incidents to ensure the safety of patients and staff at all times. Ref: 5.2.2 and 5.2.3
	Response by registered person detailing the actions taken: A General Risk Assessment has been completed by the ward team, including a review of staffing levels. The Fire Risk Assessment has been reviewed and all points have been actioned. A contingency plan is in place to manage any occurance of serious incidents that may occur. The Senior Manager on call is consulted, staff have been made aware of the Trust Zero Tolerance Policy and the PSNI are contacted, if required. Datix reports are completed and any areas of learning are identified and reviewed by the inpatient governance lead to identify themes. Any learning is shared at the Addiction Team Leaders meeting for onward discussion with their teams. A review of staffing levels has been completed and the need for increased staffing, particularly on night duty has been considered. Staffing levels will be kept under continual review and will be increased, based on acuity levels. The Senior Management Team will also discuss the need for additional investment to increase staffing levels with the Commissioner.
Area for improvement 5 **Ref:** Standard 5.1 Criteria 5.3 **Stated:** First time **To be completed by:** 31 July 2023	The South Eastern Health and Social Care Trust should record senior management visits to the ward, to include the purpose of the visit and the findings, and actions required. Ref: 5.2.7
	Response by registered person detailing the actions taken:

	A template has been developed to ensure that all future ward visits by Trust Senior Management are recorded and retained within the ward. This will include the purpose of the visit, any specific discussions or escalations to senior management and the immediate actions taken.

Please ensure this document is completed in full and returned via the Web Portal

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