Unannounced Follow Up Inspection Report
12 April 2018

Ward 15 Shimna House
Addiction Service
Downshire Hospital
Downpatrick
BT30 6RA

Tel No: 028 44513922

Inspector: Cairn Magill

www.rqia.org.uk

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 14 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 and, low level psychological interventions with support from alcohol anonymous (AA) and Narcotics Anonymous (NA).

The ward is a sub-regional ward that provides in-patient service to patients from the South Eastern, Belfast and Southern Health and Social Care Trusts. The ward is piloting a new scheme to offer the service to patients with alcohol related brain damage (ARBD). Two of the 14 beds are assigned to accommodate patients with ARBD.

The ward's multidisciplinary team consist of consultant psychiatrists, medical staff, nursing staff, health care assistants and occupational therapists. The ward is further supported by peer advocates, a health development specialist in alcohol and drugs one day a week and community addiction teams.

On the day of inspection there were seven 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 spacious, warm and welcoming. There were single and twin bedrooms. Sleeping accommodation was gender specific. The ward had a quiet room for patients, a separate dining room and a spacious day room. Additional seating was provided in the glass fronted foyer.

3.0 Service details

Responsible person: Mr. Hugh McCaughey	**Ward Manager:** Paul Watterson
Category of care: Addiction Service	**Number of beds:** 14
Person in charge at the time of inspection: Angela McShane; Deputy Ward Manager	

4.0 Inspection summary

An unannounced follow-up inspection took place on 12 April 2018.

The inspection sought to assess progress with findings for improvement raised from the most recent previous unannounced inspection 2 November 2016. This inspection also assessed if Ward 15 Shimna House was well led.

There were four areas of improvement identified at the most recent inspection. Two areas of improvement in relation to personal safety alarms and record keeping were assessed as met.

One area for improvement in relation to the review of policies was assessed as partially met however this was removed as these policies are currently being review by the Trust policy review team as part of the International Standardisation for Organisations (ISO) accreditation process. One area of improvement in relation to the provision of a social work service was assessed as not met.
Three new areas for improvements were made. A high risk action point highlighted in the fire risk assessment had not been addressed. Staff meetings were not held regularly and staff supervision was not completed in accordance with Trust policy.

The inspector observed the ward had reconfigured rooms upstairs and now had a quiet room which is accessible to patients. It was also noted the Trust had purchased more comfortable chairs for patients to sit on in the day room where most of the group sessions/therapy occurs.

Patients Views

Three patients met with the inspector and completed the patient questionnaire. Patients stated that they were satisfied that care on the ward was safe, effective, compassionate and the service was well-led.

Patients said that the therapy sessions were helpful toward their recovery and staff were supportive.

“I feel I could go to any of the nurses and they would deal with it.”

“They can be firm with you when it’s needed which is a good thing. They are very firm but fair and respectful.”

“I feel very safe here.”

“Staff here are very, very patient and understanding. They take time to listen to you and they put you at ease.”

“It can be quite piercing in treatment but I fully accept that. All staff are quite happy to sit and talk with you on a one to one.”

“They don’t judge. I think that most patients picked that up very quickly. They treat us very well.”

One patient stated they had learned a lot … “they covered the physical and mental health issues around alcohol and attitudes and behaviours and the effects on the family.”

“X, the ward manager is a great guy. Everybody seems to get on well together.”

“Staff always help us understand why certain rules are in place.”

“They treat us all in our own rights and according to our needs.”

“The food is fresh and quality is good but it can be quite repetitive.”

Relatives Views

No relatives were available to meet with the inspector.

Staff Views
Four nursing staff and one visiting professional met with the inspector. All staff reported they felt the ward was safe, effective, compassionate and well-led. Staff informed the inspector that they knew how to report any concerns in relation to patient safety, vulnerable adults, child protection, ward environment and care practices.

“All patients get the same care and attention while they are here.”

“The MDT are very good. We all work really well together. I can go to anybody at any time.”

“At 9 -9.30am there is a huddle meeting and we receive an update from the day before so that the doctors know who to see first.”

“Housing issues are a big thing for patients upon discharge…we need a social worker.”

“The moment patients come in through the door we show them around and go through the work book, care plans and explain the treatment programme and outline the approach of the ward.”

“The Ward manager is very good and encourages training.”

“I feel valued and listened to. “

“We are trying to build up the OT service.”

“We see all patients on a one to one basis and in groups.”

“People go out of their way to build therapeutic alliances. They put thought in what they do.”

“This ward is exceptionally well led. Safety is paramount. The ward manager and his team run a good ship”

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

4.1 Inspection outcome

Total number of areas for improvement	Four

The four areas for improvement include one being restated for a second time. Three new areas for improvement were identified in this inspection.

These are detailed in the Quality Improvement Plan (QIP).

Areas for improvement and details of the QIP were discussed with senior Trust representatives, members of the multi-disciplinary team, the ward manager and ward staff as part of the inspection process. The timescales for completion commenced from the date of inspection.

5.0 How we inspect

The inspection was underpinned by:

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

The following areas were examined during the inspection:

- Care Documentation in relation to four patients.
- Ward environment.
- Advocacy service.
- Link Nurse responsibility.
- Supervision dates.
- Pre-admission treatment agreement.
- A range of workbooks to aid recovery.
- Information booklets for Patients and Family members on Ward 15.
- Care plan audit tool.

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

We reviewed the areas for improvements made at the previous inspections and an assessment of compliance was recorded as met/partially met and not met.

6.0 The inspection

6.1 Review of areas for improvement from the last unannounced inspection 2 November 2016

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

Areas for Improvement from last inspection		Validation of Compliance
Area for improvement 1 **Ref**: 5.3.1 (f) **Stated: First Time**	All staff to be issued with personal safety alarms. **Action taken as confirmed during the inspection**: All staff were issued with personal safety alarms. Staff informed the inspector that each staff member has been assigned a personal alarm and it is their individual responsibility to ensure it is fully charged and to test it weekly to ensure it is working properly.	**Met**
Area for improvement 2 **Ref**: 5.3.1 (f) **Stated: First Time**	Record Keeping. Identifying person responsible for following up actions agreed at the Team Assessment Meeting (TAM) and evidence of action taken in Maxims systems. **Action taken as confirmed during the inspection**: The inspector reviewed the minutes of the weekly team assessment meetings (TAM) of four patients. The template to record the TAM minutes had been modified to incorporate contributions from all members of the multidisciplinary team. The minutes also recorded actions agreed and the person responsible to ensure the action has been completed. There is also provision for staff to record the date the action has been completed. The inspector was satisfied that the records reviewed had the above detail recorded.	**Met**
Area for improvement 3 **Ref**: 5.3.1 **Stated: First Time**	Review and Update of Policies **Action taken as confirmed during the inspection**: The inspector noted that the ward manager had compiled a file containing 50 policies that were relevant to the ward for staff access.	**(Partially Met) and Removed**

	The inspector noted a number of policies to be in date or scheduled for review. Senior managers reported at feedback that all policies and procedures are currently being reviewed as the Trust are undergoing International Standardisation for Organisations (ISO) accreditation. The Trust policy review team is responsible for this review. A schedule to review policies was in place. As these policies are currently being reviewed by the Trust policy review team this area for improvement will not be restated a second time. RQIA will continue to monitor Trust policies and procedures through inspection processes.	
Area for improvement 4 **Ref**: 6.3.1(a) **Stated: First Time**	Social Work Service **Action taken as confirmed during the inspection**: The multi-disciplinary team did not include a social worker. This issue was discussed at feedback and senior managers reported that the Trust is in the process of reconfiguring social work allocation from within the programme of care to have a permanent social worker allocated to the ward. This area for improvement will be restated for the second time.	**Not met**

6.1 Is the Service Well Led?

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

Evidence of Good practice

Evidence of good practice was noted in the following areas; pre- admission assessment, the development of the information booklet available for patients and their families, a range of updated workbooks and resources books for patients. The ward also had a full and part-time occupational therapist (OT). The OT's stated that they were planning on developing a range of activities for patients and taster sessions were ongoing, some of the options included; a recovery choir, mindfulness, photography, gardening and Pilates.

There were a number of new safety, quality, experience (SQE) tools to capture and record patient experience which also reflects adherence to good practice and standards. The ward had just received posters which are waiting to be put up to report on the number of patients admitted in a month, the number of patients who completed the programmes, number of patients discharged who had a relapse, and the number who were prescribed prevention medication. The posters also enabled staff to record outcomes of kardex audits and attendance at therapeutic groups such as relatives group, those attending monthly open group meeting and family days, and space to record comments and compliments about Ward 15. The poster also had additional provision to record performance indicators such as "You said, We did."

There was evidence of the ward manager cascading learning derived from Serious Adverse Incident reviews.

Areas requiring improvement

The ward still did not have a dedicated social worker as part of the multi-disciplinary team. Given that Ward 15 is a sub-regional addictions unit and the complexities of patients being admitted the need for a social worker to be assigned to the ward is a priority. This area for improvement has been restated.

The ward had a fire risk assessment completed on 15 August 2017 with an action plan attached to address risks identified. Each action point had been assessed in accordance of priority and classified as 'A', 'B' or 'C'. One category 'A' action point which means items which are serious breaches of standard, having the potential to cause serious injury and which should receive immediate attention was not actioned. This was identified as a new area for improvement.

Staff meetings were noted to be infrequent. The inspector noted that from May 2016 to March 2018 there were 6 staff meetings.

The supervision dates for staff were also reviewed. The frequency of supervision did not occur in accordance with the South Eastern Trust supervision policy. This has been identified as a new area for improvement.

Other Findings

Clinical Room

Staff reported to the inspector concerns in relation to the size of the clinical room. The inspector viewed the clinical room and noted it to be clean and well organised although it was cramped. The clinical room was small and did not have adequate space for all the equipment which was required to be stored in it. This issue was discussed at feedback and senior managers reported that the extension of Ward 15 clinical room was on the list of priorities and the Trust is planning to address within the capital funds available. The inspector reviewed the directorate prioritisation plan and noted this to be the third priority for action.

Ability to upload specific templates to the generic electronic patient information system, MAXIMS

During the review of care documentation the inspector noted staff worked with patients to complete their sober living plan. However the Maxims system did not allow a copy of this

document to be uploaded. The patient normally takes the sober living plan home with them when discharged. It is not standard practice to retain a hardcopy of this plan. The inability to access a copy of the patient's sober living plan on the electronic patient information system in the event of the patient being readmitted meant that it could not be reviewed to see which aspect of the plan needed amended. Ward staff reported they will endeavour to retain a hardcopy of each patient's sober living plan. Senior managers at feedback also advised that a working group has been established from all services to identify which documentation needs to be electronically available. This information will be considered when the next version of Maxims is rolled out.

Risk assessments of patients admitted from outside the South Eastern Trust area arrive in paper format as the electronic patient information systems from the Southern and Belfast Trusts are not compatible with the South Eastern Trust's system. Ward staff retype and upload information contained in the patient's risk assessment onto the Maxims system to enable staff to update the risk assessment throughout the patient stay. A hardcopy is printed and forwarded to the patient's respective community team.

Ward 15 Shimna House as a Stand-alone unit

There was discussion at feedback in relation to the ward being a stand-alone unit and the vulnerability this creates for patients and staff in the event of an incident occurring. Whilst staff have been issued with individual personal alarms the only means of alerting other staff from other wards in the main hospital building was to phone across and request staff to assist with the incident. This would require a staff member off the floor to make the call and mean they would not be available to assist with the incident. Staff were aware they can call upon staff from the community addiction team which occupy the next nearest building; however this is unstaffed outside office hours. The ward does not usually have many incidents which require alarms to be activated. However in such circumstances it was acknowledged there will be a delay in PSNI or staff from other wards onsite arriving. Senior managers from the Trust have identified this as a risk and have listed this as a priority one in the Mental Health prioritisation action plan.

7.0 Quality Improvement Plan

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

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

7.1 Actions to be taken by the service

The quality improvement plan should be completed and detail the actions taken to meet the areas for improvement identified. The responsible person should confirm that these actions

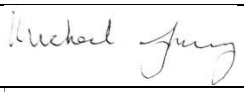
have been completed and return the completed quality improvement plan to RQIA via the web portal for assessment by the inspector by 7 June 2018.

Quality Improvement Plan

The responsible person must ensure the following findings are addressed:

Area for Improvement No. 1 **Ref:** 6.3.1(a) **Stated:** Second Time **To be completed by:** 12 October 2018	Social Work Service **Response by responsible individual detailing the actions taken:** The Senior Manager is seeking to recruit a Social Worker that will input directly into Shimna House. We are undertaking a process of restructuring our staff recruitment process to facilitate this within this financial year.
Area for Improvement No. 2 **Ref:** 5.3.1 (e) **Stated:** First Time **To be completed by**: 12 July 2018	Action points noted in the Fire Risk assessment were not actioned. **Response by responsible individual detailing the actions taken:** The Estates Fire Team undertook an inspection of this property and considered its use, layout, fire loading on and adjacent to circulation routes, occupant profile and fire safety management arrangements. Various fire safety guidance documents regarding existing fire resisting elements of construction were also reviewed. On this basis, and in this instance, Estates would consider it reasonable to downgrade FRSNI's *'Fire Risk Priority A'* to *'Fire Risk Priority C'* i.e. *'…….should receive attention as part of the building maintenance procedures or programme'.*
Area for Improvement No. 3 **Ref:** 5.3.1 **Stated:** First Time **To be completed by:** 12 June 2018	Staff Meetings are not happening regularly **Response by responsible individual detailing the actions taken:** Monthly staff meetings had not been taking place as regularly as they should have. The Ward Manager has rescheduled these for the forthcoming year and they have commenced with immediate effect. This will be reviewed by the Addiction Services Manager on a monthly basis.
Area for Improvement No. 4	Supervision was not occurring as frequently as was stipulated in the South Eastern Trust supervision policy.

Ref: 5.3.3 **Stated:** First Time **To be completed by:** 12 July 2018	**Response by responsible individual detailing the actions taken:** Clinical supervision has been agreed as per Trust policy and will be a minimum of 2 individual/group sessions per year. The service will also commit to training two additional staff members to undertake clinical supervision training to support the wider team.

Name of person (s) completing the QIP	Mr Michael Gracey		
Signature of person (s) completing the QIP		**Date completed**	06/06/18
Name of responsible person approving the QIP	Mr Don Bradley		
Signature of responsible person approving the QIP		**Date approved**	07/06/2018
Name of RQIA inspector assessing response	Wendy McGregor		
Signature of RQIA inspector assessing response	Wendy McGregor	**Date approved**	14 June 2018

Please ensure this document is completed in full and returned to RQIA via the web portal

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews