Unannounced Follow Up Inspection Report
12- 13 September 2017

Carrick and Evish Ward
Acute Mental Health Admission
Grangewood Hospital
Gransha Park
Londonderry
BT47 6TF

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Inspector: Audrey McLellan
Lay Assessor: Alan Craig

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Assurance, Challenge and Improvement in Health and Social Care

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

Evish and Carrick are acute admission mental health wards situated in Grangewood Hospital. Evish provides assessment and treatment for female patients aged 18-65 and Carrick provides the same service for male patients aged 18-65. The wards are part of single-system crisis service which includes a crisis response home treatment team and an acute day care service. The service operates as one single seamless team working closely with community teams.

The wards can accommodate up to 30 patients and each patient has a single ensuite bedroom. Each ward has three bedrooms which can be converted into an integrated Psychiatric Intensive Care Unit (PICU).

The wards are supported by a multi-disciplinary team (MDT) including; nursing staff, two consultant psychiatrists, two staff grade doctors, 2 trainee psychiatrists, an occupational therapist, a pharmacist and two social workers. There is one ward manager responsible for the management of both wards.

On the day of the inspection there were ten patients on Evish ward and nine patients on Carrick ward. There were four patients on Evish ward and five patients on Carrick ward who had been detained appropriately in accordance to the Mental Health (Northern Ireland) Order 1986.

3.0 Service details

Responsible person: Anne Killgallen	**Ward Manager:** Tony Simmons
Category of care: Acute Admissions	**Number of beds:** 30
Person in charge at the time of inspection: Julie Clarke	

4.0 Inspection summary

An unannounced follow-up inspection took place over two days from 12 – 13 September 2017.

The inspection sought to assess progress with findings for improvement raised from the most recent unannounced inspection on 25 - 27 October 2016.

The inspector noted that the ward had made improvements from the previous inspection. Patient risk assessments were recorded on to the PARIS system with clear management plans in place. The wards information booklet had been reviewed and updated. Information was

collated and analysed in relation to vulnerable adult referrals and improvements had been made in record keeping.

As a result of this inspection new areas for improvement were identified in relation to the unkempt garden areas and access to the baby and mother unit as this could only be accessed by walking through the main ward. An area of improvement was also made in relation to the completion of the MDT template as a number of previously completed MDT templates did not name who the responsible person was for completing each action identified in the outcomes of the MDT meeting.

The Trust had recently transferred patients' risk assessments from paper records to a new electronic recording system called PARIS. When the inspector reviewed the risk assessments on the PARIS system there was evidence that assessments and management plans were in place. However, on reviewing this system there appeared to be a number of risk assessments in place which had been completed by other mental health services. This was discussed with a senior Trust representative who advised that when a patient transfers through various different services information in their comprehensive risk assessment should migrate over to the new assessment to ensure no information is lost. Therefore there should be only one risk assessment and management plan in place. However, it appears that there is a problem within this process. The Trust advised that there is a PARIS migration group who are dealing with all issues relating to the PARIS system and the concern identified by the inspector will be discussed at this group to rectify this issue. A new area for improvement has been made in relation to this.

The inspector was concerned regarding the under reporting of a serious adverse incident which occurred on the ward on 12 August 2017. This incident met the criteria for investigation in accordance to the 'Health and Social Care Board's Procedure for the Reporting and Follow up of Serious Adverse Incidents, November 2016'. It was concerning to note that this was the second time RQIA have had to raise this issue with the Trust as this had been previously raised in October 2016 in relation to another ward within the Trust. A serious concerns meeting was held on 2 October 2107 with senior representatives from the Trust to discuss this concern. It was agreed at this meeting that the Trust would review its procedures to ensure robust mechanisms were put in place to ensure all incidents which met the criteria for reporting under the HSCB procedure are reported through this process. A new area for improvement has been made in relation to this.

Views of relatives

The lay assessor spoke to one relative. The relative was very complimentary about the care and treatment provided on the ward. They stated that their relative was treated with dignity and respect and that the staff were very caring. They made the following comments:

"The nurses give X 100%.....I'm in everyday for three hours. I have to give the staff 100%.... the feedback they give me is 100%"

Views of Patients

The lay assessor spoke to six patients on the wards. Patients were generally complimentary about the care and treatment they were receiving. Patients stated they were involved in their care and treatment and they felt safe on the wards. They confirmed there were activities on the wards for them to take part in each day and they stated they can also attend the acute day

hospital. They advised that staff treat them with respect and always listened to their views and took these into consideration when planning their care and treatment. They confirmed that they attend their MDT meetings each week and they stated that all professionals at these meetings listen to their views and explain any changes in their care and treatment plans.

Four patients made a number of negative comments regarding their care and treatment. These related to restrictions on the ward, discharge arrangements and the lack of activities on the ward. The inspector discussed these concerns with ward staff and reviewed the care documentation for these four patients. The inspector was satisfied with the care and treatment in place for all four patients.

Patients made the following comments:

"I don't trust anybody but myself… they made me feel worse by telling me I was unwell and extended my detention…..it's a nice peaceful environment and you get fed more than enough".

"It's not bad just a bit restrictive……if you want to go out for a while you have to go thorough too many things".

"If you have something personal you can talk to staff on a one to one……it's quiet you feel safe. If you have a problem you can come to staff".

Views of staff

Inspectors spoke to four members of the multi-disciplinary team. Staff confirmed that they enjoyed working on the ward and stated they felt supported by the ward manager. Staff said the ward was safe and that the care and treatment was effective. Staff stated they had up to date supervision and appraisals in place. Staff made the following comments:

"I love working on this ward".

"There is a good level of care on this ward…. it's a good ward to work in….there is good teamwork here".

"I really enjoy this post".

The inspector spoke to a member of staff from the hospital's support services. They stated they were involved in the 'safety brief' each morning where issues are discussed such as risks, incidents and any concerns on the ward. They stated they felt part of the team and enjoyed working on the ward. They made the following comment about the care on the ward:

"Staff are very compassionate towards patients".

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	Eight

The total number of areas for improvement comprise of:

- two restated for a second time
- one reworded and restated for a second time
- five new areas for improvement

These are detailed in the Quality Improvement Plan (QIP). Areas for improvement and details of the QIP were discussed with a senior Trust representatives and ward staff as part of the inspection process. The timescales for completion commenced from the date of inspection.

Escalation action resulted 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

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 environments
- Staff duty rota
- Activity schedule
- Fire risk assessment
- Ligature risk assessment
- Medicine Kardexes
- Ward information booklet
- Usage of bank hours

During the inspection the inspector and the lay assessor observed staff working practices and interactions with patients using a Quality of Interactions Schedule Tool (QUIS). All interactions observed between staff and patients were noted to be positive. Staff were observed sitting

talking with patients and escorting patients out to the acute day hospital. Staff were observed serving patients their meals and offering assistance when required. During all interactions patients were treated with dignity and respect by staff.

Areas for improvements made at the previous inspections were reviewed 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 25-27 October 2016

The most recent inspection of Carrick and Evish Wards 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		Validation of Compliance
Number/Area 1 **Ref**: Standard 5.3.1(a) **Stated:** First Time	A fire safety assessment had been completed on 5 September 2016 for Carrick Ward and on 19 July for Evish Ward. A number of actions were assessed as high risk in the Evish assessment but there is no evidence that these had been actioned within the timeframe.	**Met**
	Action taken as confirmed during the inspection: An updated fire risk assessment had been completed on 4 July 2017 for both Evish and Carrick Wards. There were a number of actions required to be completed by 4 October 2017. RQIA requested that the Trust forward evidence that this work was completed. This was received on 9 October 2017.	
Number/Area 2 **Ref**: Standard 5.3.1(a)	Risk management plans were in place in the review section of the template. Concerns were raised regarding this as staff had to review these updates to identify the most up to date management plan.	

Stated: First Time	**Action taken as confirmed during the inspection**: The inspector reviewed four patient risk assessments which were now transferred over to the PARIS system. There was evidence in these records that patient management plans were in place under the heading 'safety plans' and these were reviewed weekly by the MDT.	**Met**
Number/Area 3 **Ref**: **Stated:** First Time	The ward information booklet could be enhanced by adding information regarding the complaints procedure, the patient and client counsel and the carers advocate service (CAUSE).	**Met**
	Action taken as confirmed during the inspection: The inspector reviewed the ward information booklet and there was evidence that this booklet had been updated with information regarding the complaints procedure, the patient and client counsel and the carers advocate service (CAUSE).	
Number/Area 4 **Ref**: Standard 5.3.1(f) **Stated:** First Time	Some of the care documentation was not fully completed: • The MDT template was completed in each care record to detail decisions agree**d** and the responsible person for implementing agreed actions. However, when the action was completed this was not always signed and dated. • The medication on admission template had not been signed in two out of the four care records. • Two out of the four interim care plans had not been completed fully. • The formulation template was not completed in all four records reviewed.	**Partially Met**
	Action taken as confirmed during the inspection: The inspector reviewed four sets of care records and there was evidence that the medication on admission template had been signed and the interim care plans had been completed. The formulation template had been moved to the MDT template and was reviewed each week at the MDT meeting.	

	However the MDT section did not always evidence if the action agreed at the meeting had been completed. This area for improvement will be reworded and restated for a second time as three out of the four points have been met. In a number of MDT templates it did not name who the responsible person was for completing each action as it stated under responsible person MDT. A new area for improvement will be made in relation to this.	
Number/Area 5 **Ref**: Standard 5.3.3(a) **Stated:** First Time	The carer advocate from CAUSE did not have a presence on the ward and therefore missed opportunities to meet with patients' families to inform them of their role.	**Met**
	Action taken as confirmed during the inspection: The ward manager had a discussion with a representative from CAUSE in relation to CAUSE's role on the ward. They stated CAUSE were not in a position to be present on the ward during visiting times. However, information regarding their service has now been included in the ward information booklet. It was agreed that information leaflets on the service would be displayed on the entrance to the ward. However the inspector did not see any evidence of this. The ward manager agreed to speak with CAUSE regarding this and will ensure this is implemented.	
Number/Area 6 **Ref**: Standard 6.3.2(a) **Stated:** First Time	During an observation of a group session in the acute day hospital the inspectors noticed that the session was interrupted unintentionally by two visitors. One visitor came into the day hospital to deliver mail and another had been in a meeting with a staff member from the day hospital. This was noted to distract patients in the session.	
	Action taken as confirmed during the inspection: There is now a system in the day hospital to prevent interruptions to group activities. The times for delivery of mail have been rearranged so that this does not take place during group sessions. A	**Met**

	sign is erected on the entrance to the day hospital to advise of the group sessions taking place and not to interrupt.	
Number/Area 7 **Ref**: Standard 5.3.2(c) **Stated:** First Time	Information was not collated and analysed in relation to vulnerable adult referrals as this could not be recorded onto the DATIX system.	**Met**
	Action taken as confirmed during the inspection: Information is now collated and analysed in relation to all vulnerable adult referrals. The nursing support officer records this information and keeps a record for the ward manager to review and analyse.	
Number/Area 8 **Ref**: Standard 5.3.1(f) **Stated:** First Time	Medicine kardex did not always record the indication for Pro Re Nata (PRN) medication and whether it was to be administered as 1st line or 2nd line.	**Not Met**
	Action taken as confirmed during the inspection: The inspector reviewed four medicine kardexes. Within all four records there was no indication for Pro Re Nata (PRN) medication and whether it was to be administered as 1st line or 2nd line.	
Number/Area 9 **Ref**: Standard 4.3.(j) **Stated:** First Time	There was no clinical psychologist attached to the wards to form part of the MDT.	**Not Met**
	Action taken as confirmed during the inspection: The Trust's Director of Mental Health service has written to the HSCB in relation to securing funding for this post. However at the time of the inspection there was no clinical psychologist attached to the ward to form part of the MDT team.	

7.0 Quality Improvement Plan

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 QIP via the Web Portal for review by the inspector by 8 November 2017.

Quality Improvement Plan

The responsible person must ensure the following findings are addressed:

Area for Improvement No. 1 **Ref:** Standard 5.3.1(f) **Stated:** First Time **To be completed by:** 11 October 2017	In a number of MDT templates it did not name who the responsible person was for completing each action.
	Response by responsible individual detailing the actions taken: This issue was discussed at the Crisis Service quality improvement group Clinical Microsystems and an action agreed to address this area. At the MDT meetings the planned actions will be checked, reviewed and signed off by the MDT. The Charge Nurse will design an audit template to ensure compliance, will audit on a regular basis and will feed back the results through the Clinical Microsystems and staff meetings.
Area for Improvement No. 2 **Ref:** 5.3.1 (f) **Stated:** First Time **To be completed by**: 11 October 2017	Concerns were raised regarding the under reporting of a serious adverse incidents which happened on the ward on12 August 2017. This incident met the criteria for investigation under the HSCB, Procedure for the Reporting and Follow up of Serious Adverse Incidents, November 2016. It is concerning to note that this is the second time RQIA have had to raise this issue with the Trust.
	Response by responsible individual detailing the actions taken: As per discussions at the Serious Concerns Meeting on 02/10/2017 this incident has been reported to the HSCB as an SAI and is currently under investigation and review. The deadline for submission is 28/11/2017. An NIAIC incident report (WT-14626) was submitted on 22/09/2017. An early learning communication has been sent to all Trusts.
Area for Improvement No. 3 **Ref:** 5.3.1 (a) **Stated:** First Time **To be completed by:** 8 November 2017	Previous comprehensive risk assessments completed for patients by other mental health services prior to their admission to the wards, had not been migrated over to the current risk assessment.
	Response by responsible individual detailing the actions taken: This area for inspection has been discussed with the Chair of the PARIS Working Group and the item has been placed on the agenda for the next PARIS Working Group meeting to be held on 05/12/2017. The Charge nurse will highlight this issue to ward staffs through weekly staff meetings and daily safety briefings.
Area for Improvement No. 4 **Ref:** 4.3 (i)	Access to the baby and mother unit should be reviewed as this unit was situated at the end of the ward therefore this could create unnecessary risks to young children/babies when they are brought to visit their mother.

Stated: First Time **To be completed by:** 12 April 2017	**Response by responsible individual detailing the actions taken:** Access to the general ward area is controlled through swipe access doors. All visitors are therefore screened. All staff are aware of safeguarding considerations in relation to any child under the age of 16 years visiting parents or relatives on the ward. This includes the general wared area and the facilities that are used for mother and baby admissions. Escort/chaperoning arrangements are put in place as required on the basis of assessed needs and risk assessment. All staff have mandatory safeguarding children training. Daily Safety Briefs highlight all areas of safety for all staff to be aware of within their area of work whilst on duty.
Area for Improvement No. 5 **Ref:** 6.3.2 (a) **Stated:** First Time **To be completed by:** 8 November 2017	The garden areas were unkempt. Both garden areas were not a therapeutic space for patients to relax in. **Response by responsible individual detailing the actions taken:** A maintenance contract is in place for general ground maintenance. Some work has subsequently been undertaken as per the contract. The Charge Nurse will submit works requests for power-hosing of enclosed garden spaces and outdoor areas. A system is in place for the daily and weekly checks in regard to the environment which will highlight areas for action on a regular basis. The Charge Nurse has agreed with Estates Services to a review of the contract for upkeep of the garden areas.
Area for Improvement No. 6 **Ref:** Standard 5.3.1(f) **Stated:** Second Time **To be completed by:** 11 October 2017	The MDT template did not always evidence if actions agreed at the meeting had been completed. **Response by responsible individual detailing the actions taken:** Actions here are linked to the actions taken in area for improvement number 1 within this Quality Improvement Plan
Area for improvement No. 7 **Ref**: Standard 5.3.1(f) **Stated:** Second Time **To be completed by:** 11 October 2017	Medicine kardex did not always record the indication for Pro Re Nata (PRN) medication and whether it was to be administered as 1st line or 2nd line. **Response by responsible individual detailing the actions taken:** Subsequent to inspection this area for improvement was discussed at the Crisis Service Quality Improvement meeting, Clinical Microsystems. Medical staff and the Mental Health Pharmacist have agreed to review prescribing practice and to audit this area.
Area for improvement No. 8	There was no clinical psychologist attached to the wards to form part of the MDT.

Ref: : Standard 4.3.(j) **Stated:** Second Time **To be completed by:** 12 April 2017	**Response by responsible individual detailing the actions taken:** The Head of Service and Professional Lead for Clinical Psychology will submit a proposal for dedicated Clinical Psychology for acute in-patient care to the Adult Mental Health Senior Management Team.

Name of person (s) completing the QIP	Tony Simmons		
Signature of person (s) completing the QIP		**Date completed**	8/12/17
Name of responsible person approving the QIP	Dr Anne Kilgallen		
Signature of responsible person approving the QIP		**Date approved**	8/12/17
Name of RQIA inspector assessing response	Audrey McLellan		
Signature of RQIA inspector assessing response		**Date approved**	11/12/17

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