The Regulation and Quality Improvement Authority

Inspection Report

4 May 2023

Carrick 1

Type of service: Addictions
Address: Holywell Hospital
60 Steeple Road
Antrim
BT41 2RJ
Telephone number: 028 9446 5211

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: Northern Health and Social Care Trust (NHSCT) **Responsible Individual:** Ms Jennifer Welsh Chief Executive	**Registered Manager:** Rose McGuckien
Person in charge at the time of inspection: Rose McGuckien	**Number of registered places:** 9
Categories of care: Addictions Service	**Number of patients accommodated in the Ward on the day of this inspection:** 8
Brief description of the accommodation/how the service operates: Carrick 1 is a regional inpatient addiction unit which can accommodate nine 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 Carrick 1 took place on 4 May 2023 between 9am and 5pm. The inspection was completed by two care inspectors.

The inspection focused on ten key themes including, environment, adult safeguarding and incident management, 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.

One area for improvement (AFI) was identified.

Although an AFI was identified, the outcome of this inspection was positive. Areas of good practice were noted in relation to the patient dining experience, patient food choices and options, collaborative working with BHSCT and WHSCT community addictions services, and medication audits.

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 wards 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 seven patient questionnaires during the inspection, the majority 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 to Carrick 1 was undertaken on 21 May 2018 by a care inspector; no areas for improvement were identified.

5.2 Inspection findings

5.2.1 Environment

The ward was bright and well presented with inspirational and motivational messages displayed on the walls throughout. There were a number of rooms allocated for patient use, the majority of which were small spaces. The lounge was crowded with insufficient seating when all eight patients were using it. An additional, much larger, lounge space was available; however, this space was also used for meetings and ward rounds, therefore not available to patients at all times. The Trust should consider how the available space is best used to meet patient needs.

Patients had their own bedrooms, one of which had an en-suite shower room. Communal, single sex, bathroom facilities were available nearby to patient bedrooms.

Patients and their families could use a family visiting room which had books, toys, and games for younger children visiting. The room was located near the entrance, enabling privacy. Visiting during patients' activity times is limited in order to minimise the disruption to structured programmes.

The dining area was bright and spacious with adequate seating for all patients. It was positive to note various relevant leaflets were displayed within the dining area; including, Mealtimes Matter (Public Health Agency), The International Dysphagia Diet Standardisation Initiative (IDDSI), and advice relating to choking. Tea, coffee, and cold drinks stations were available for patients along with fresh fruit and light snacks.

Patients did not have access to their own phones but did have access to a ward pay phone. The pay phone was located outside the small lounge area and in a main thoroughfare which could not be considered private. Patients using the phone could be heard by all in the surrounding vicinity. The Trust should consider relocating this phone to ensure patients' privacy.

An extensive range of information pertaining to addiction was available throughout the ward, including contact details for patient advocacy and addiction support groups.

The most recent fire risk assessment (FRA) was available. This had been reviewed within the required timeframes. The action plan detailed the actions required; however, there were no dates for the completion of actions. It is recommended the Trust review the FRA to include action completion dates.

A copy of the General Risk Assessment (GRA) was available for review. This detailed risks identified in the ward and actions required. The GRA had been recently reviewed. A ligature risk assessment (LRA) was completed as part of the wards general risk assessment. This included details of the mitigations taken against the identified risks. All risks were being appropriately managed and regularly reviewed.

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.

Most of the incident reports recorded for the last 12 months were reviewed. The majority were graded consistently; however, some inconsistencies were noted for incidents where patients reported assaults on them that had occurred in the community. It is recommended the Trust review the recording and grading of such incidents to improve consistency, and enable the escalation of such incidents to the relevant persons and services. This will improve outcomes for patients.

There was evidence that ASG referrals (APP1) were made to the ASG team. The detail in the APP1 forms was not consistently reflected in the Datix incident record. This disparity in recording had the potential to impact negatively on patient care as all staff may not have access to both APP1 forms and Datix. It is recommended the Trust review the detail recorded in incident forms.

It was positive to note the ward Social Worker had oversight of all APP1 forms submitted to ASG team. There were no ward related ASG investigations open at the time of the inspection.

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 workers, occupational therapist (OT), nursing staff, and psychology staff.

There were a small number of staff vacancies within the nursing team. Staff rotas reflected safe staffing levels and evidenced the use of Trust staff additional hours and agency staff to cover deficits.

There was evidence of limited staff on night duty. The ward manager gave assurances that assistance was available from other wards at night for staff breaks and when additional resources were needed. Assistance could be requested by phone or by triggering an alarm system in the event of an emergency.

The staff training matrix was reviewed for mandatory training and e-learning. The overall training compliance for staff requires improvement. The Trust must ensure all staff have completed all mandatory training within the required timeframes and that there is effective oversight of this.

An area for improvement has been identified in relation to staff training.

5.2.4 Physical Health

Patients physical health records were reviewed. Records reflected that patient's physical health needs were met. Records reflected detailed recording in relation to physical health checks and follow up care. All patients received a physical examination by medical staff as part of an admission checklist.

Patients completing detoxification during their care and treatment have the potential to require additional physical health support. Carrick 1 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.

A wide range of physical health checks were completed throughout the duration of patients care and treatment. An example of these included blood monitoring, urine screening, nutritional assessment, and cardiology assessments. Patients with a known medical condition received support with this and follow up treatment as necessary. Patients spoke positively about this aspect of their care.

5.2.5 Restrictive Practice

There were no restrictive practices on Carrick 1. All patients are admitted on a voluntary basis. Patients are required to sign the pre admission treatment agreement and agree to follow this as part of their treatment programme. This includes compulsory attendance at group therapies and to be accompanied when off the ward.

The ward operates a buzzer system for entry; however, patients who wish to leave the ward can do so at any time by using an exit button which they can operate independently.

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. Seven patients completed a patient questionnaire, the majority of which reflected high levels of satisfaction with the care and treatment.

The patient dining experience was observed. There was a relaxed atmosphere and staff were available should patients require assistance or support. It was positive to note that a patient was accompanied by staff to the main hospital canteen as they did not want any of the menu options on that day.

Patients and staff described a two to four week programme of care. The average length of stay was three weeks. The programme is structured and takes into consideration input from family and friends, the final stage includes discharge plans. Patients spoke very positively about the programme.

A designated Social Worker is part of the ward MDT. One element of their role was securing appropriate accommodation for patients prior to discharge. The social worker worked in collaboration with local housing agencies to ensure patients were given the most suitable support.

A number of external agencies support the ward weekly, including Alcoholics Anonymous and Narcotics Anonymous.

Weekly patient meetings were held and "You said, we did" boards displayed the outcomes from the meetings. There was evidence that actions had been taken in response to patient feedback/comments.

5.2.7 Governance

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

The daily handover report communicated all relevant patient information from shift to shift. It included details of any incidents or issues encountered during a shift.

A hospital wide safety huddle was conducted twice daily which aimed to improve communication and enable understanding of the issues across acute services, including clinical and staffing issues.

A Safety and Quality Assurance Group Booklet was available for review. This booklet was produced monthly for SMT, and detailed incidents which occurred in acute mental health wards, and one dementia ward, within the Trust. This promotes learning across different departments/wards.

A quarterly Progress Monitoring Report is compiled for the Head of Service, Mental Health, and details the number and demographics of patients in Carrick 1. This ensures oversight of the service by members of Trust senior management.

The Consultant Psychiatrist provided a document they had written; Carrick 1 Regional Addiction Unit Holywell hospital Antrim – A Description of its role and the patient journey from admission to discharge. This document gives extensive information on the role and function of the ward, and what patients can expect from the service.

Quarterly addictions management meetings are held in conjunction with the community addictions team. Areas for discussion included; community waiting list, in-patient waiting list, planned admission dates, and movement within all three in-patient services.

Staff reported a visible presence of the senior management team (SMT) on the ward; members of SMT regularly visit the ward and spoke knowledgably about the patient care and treatment and the staffing compliment. A written record of all SMT visits were recorded.

5.2.8 Patient Flow

There were eight patients on the ward at the time of the inspection. Thirty-two 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.

Patients were referred to the service by their named worker in the community, after all non-in-patient options had been explored. The Northern Trust liaise with representatives from the Belfast Health and Social Care Trust (BHSCT) and the Southern Health and Social Care Trust (SHSCT) twice weekly to ensure they have the most up to date information pertaining to individuals waiting for admission. Carrick 1 operates a waiting list which indicates risks and priorities for individuals. Patients on the waiting list are given a predicted admission date. In the absence of a regional co-ordinator the three addiction services liaise weekly to discuss admissions and priorities for admission.

The ward prioritises all perinatal patients for the next available admission. There was evidence of close collaborative working between the ward and a NHSCT Advanced Nurse Practitioner who delivered advice to patients two mornings per week on sexual health, contraception, and relationships.

The NHSCT have six funded beds in a BHSCT residential facility, that serves as an addiction service in the community. This service is available for patients who have been discharged from the ward who require additional support in their rehabilitation journey. A similar resource is available in the Western Health and Social Care Trust (WHSCT).

5.2.9 Medicines Management

Medicines were stored in the treatment room; this room was well organised and provided private space for patients to take their medications.

Medicines and oxygen for emergency use were checked and found to be in date. Daily fridge temperature checks had been completed.

The use of pro re nata (PRN) medication, which is medication that is prescribed on an as and when necessary basis, was reviewed. Patients received PRN medication as prescribed. It was positive to note all patients had been prescribed PRN pain relief.

Diligent medication systems were in place, with evidence of good managerial oversight. Areas of good practice were noted in relation to controlled drug audits, and action plans following these audits.

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. 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	1

The total number of areas for improvement includes one that has been stated for a first time.

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

Quality Improvement Plan	
Action required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006)	
Area for improvement 1 **Ref:** Standard 4.1 Criteria: 4.3 **Stated:** First time	The Northern Health and Social Care Trust must ensure staff complete all mandatory training, relevant to their position; and ensure suitable arrangements are in place for the effective oversight of staff training. Ref: 5.2.3
To be completed by: 31 July 2023	**Response by registered person detailing the actions taken:** All staff are advised of the need to remain compliant with mandatory training. A monthly table is collated across inpatient services including Carrick One which is forwarded to the Head of Service for information; any training deficits are raised with the Ward Manager to address with the team. The lead nurse for Nurse Education & Learning for division also drives this work ensuring compliance across all the wards with mandatory training. The recent introduction of a new training system (LearnHSCNI) enables staff to view their training compliance and book onto relevant/mandatory training as necessary. Managers can also use this new system to view training compliance across their staff team. Staff on Carrick one ward are actively working to achieve full compliance against all mandatory training with a view to completion by the proposed deadline of 31 July 2023, acknowledging potential challenges in course capacity to enable completion.

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

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