Carrick 4

Holywell Hospital

Northern Health & Social Care Trust

Unannounced Inspection Report

Date of inspection: 8 & 15 May 2015

informing and improving health and social care
www.rqia.org.uk

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Our Vision, Purpose and Values

Vision

To be a driving force for improvement in the quality of health and social care in Northern Ireland

Purpose

The Regulation and Quality Improvement Authority (RQIA) is the independent health and social care regulator in Northern Ireland. We provide assurance about the quality of care, challenge poor practice, promote improvement, safeguard the rights of service users and inform the public through the publication of our reports.

Values

RQIA has a shared set of values that define our culture, and capture what we do when we are at our best:

- **Independence** - upholding our independence as a regulator
- **Inclusiveness** - promoting public involvement and building effective partnerships - internally and externally
- **Integrity** - being honest, open, fair and transparent in all our dealings with our stakeholders
- **Accountability** - being accountable and taking responsibility for our actions
- **Professionalism** - providing professional, effective and efficient services in all aspects of our work - internally and externally
- **Effectiveness** - being an effective and progressive regulator - forward-facing, outward-looking and constantly seeking to develop and improve our services

This comes together in RQIA's Culture Charter, which sets out the behaviours that are expected when employees are living our values in their everyday work.

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1.0 Introduction

The Regulation and Quality Improvement Authority (RQIA) is the independent health and social care regulator in Northern Ireland. We provide assurance about the quality of care, challenge poor practice, promote improvement, safeguard the rights of service users and inform the public through the publication of our reports.

RQIA's programmes of inspection, review and monitoring of mental health legislation focus on three specific and important questions:

Is Care Safe?

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

Is Care Effective?

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

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

2.0 Purpose and Aim of this Inspection

To review the ward's progress in relation to recommendations made following previous inspections.

To meet with patients to discuss their views about their care, treatment and experiences.

2.1 What happens on inspection

What did the inspector do:

- reviewed the quality improvement plan sent to RQIA by the Trust following the last inspection(s)
- talked to patients, carers and staff
- observed staff practice on the days of the inspection
- looked at different types of documentation

At the end of the inspection the inspector:

- discussed the inspection findings with staff
- agreed any improvements that are required

After the inspection the ward staff will:

- send an improvement plan to RQIA to describe the actions they will take to make any necessary improvements

3.0 About the ward

Carrick 4 is a locked 16 bedded ward situated on the ground floor, off the central corridor, in the main Holywell Hospital building. The ward provides a psychiatric inpatient service to both female and male patients. The main purpose and function of the ward is the recovery and rehabilitation of patients.

On the day of the inspection there were 15 patients on the ward and fourteen of these patients were detained under the Mental Health (Northern Ireland) Order 1986.

The ward was bright, clean and spacious. Privacy for patients is ensured through the provision of single rooms with ensuite facilities. A number of furnished day room areas were located throughout the ward. There was access to a garden area which was well maintained. A laundry room was available and an occupational therapy (OT) room. The nursing office is centrally located.

The deputy ward manager was in charge of the ward on day one of the inspection and the ward manager on the second day.

4.0 Summary

Progress in implementing the recommendations made following the previous inspection carried out on 27 and 28 October 2014 were assessed during this inspection. There were a total of 16 recommendations made following the last inspection.

It was noted that ten recommendations had been implemented in full.

Six recommendations had not been met. Five of these recommendations will be restated for a **third time** and one will be restated for a second time following this inspection.

Recommendations made in relation to the implementation of person centred deprivation of liberty care plans were evidenced in three of the four patient's files reviewed. In addition the inspector was pleased to note that 24 of the 26 staff currently working on the ward had attended deprivation of liberty, human rights, capacity to consent and restrictive practice training.

The inspector noted that patients had been provided an opportunity to attend their weekly multi-disciplinary meeting if they choose to do so.

The inspector reviewed the comprehensive risk assessment and risk screening tool for four patients and noted these had been completed in accordance with Promoting Quality Care guidance.

The inspector was pleased to note that in the case of those patients who had been subject to detention information in relation to the detention process and the mental health and review tribunal had been provided. However this information had not been included within the ward information handbook as per a previous recommendation.

The inspector noted that the female living area had been relocated to another area and this now provided female patients with two large communal spaces.

Despite the positive improvements it was concerning for the inspector that governance arrangements in relation to auditing of safeguarding activity and patients' finances were not in place. In addition the inspector was concerned to note that six of the 26 staff currently working on the ward had not received training in the management of patients' monies and valuables.

A previous recommendation regarding the availability of physical intervention forms post incident was assessed and it was noted that a copy of the physical intervention form was not included within the patient file. Furthermore this form could not be located on the day of inspection for the inspector to review.

Other inspection findings

Patient care plans and files

During the course of the inspection the inspector identified a number of concerns pertaining to the care and treatment of a specific patient currently on the ward. Due to the nature and confidentially of the concerns identified this was addressed separately with the Trust.

The inspector reviewed the care files for four of the 15 patients currently on the ward. A review of three of the patients' care files identified a number of concerns which were discussed with the ward and deputy ward manager at the end of the inspection.

Patient A

The inspector noted a recently completed multi-disciplinary care plan in place. In addition the patient had a further 14 separate care plans with no evidence of review since their creation. Four of these care plans had not been reviewed since December 2014 and four further care plans were core/generic. The inspector could not determine if these care plans remained relevant to the patient's care and treatment in addition to the new multi-disciplinary care plan. A recommendation has been made in relation to this.

Patient B

A review of the patient's file evidenced that the integrated care pathway had not been commenced or completed for this patient. The ward manager explained that this was due to the tool being introduced after the patient had already been on ward for a long period of time. A recommendation has been made in relation to this.

Patient C

A review of the patient's file evidenced that the patient had been transferred to the ward 18 days prior to the inspection. The inspector noted that the integrated care pathway for the patient was incomplete; there was no multi-disciplinary (MDT) interim care plan in place and no care plans or risk assessments to reflect the patient's care and treatment needs whilst on this ward. It was further concerning that the admitting doctor had indicated that the interim MDT care plan had been created when there was no evidence to support this. However the inspector reviewed a completed multi-disciplinary care plan received post inspection.

Bathroom

During a tour of the ward the inspector noted that the only bath available on the ward was currently out of use. This had been appropriately reported by ward staff to the trust estate services department. Despite this ward staff were unaware of a date when the bath would be repaired. A recommendation has been made in relation to this.

Profiling beds

A serious adverse incident resulting in a fatality concerning the use of a profiling bed as a ligature point occurred in 2013. In December 2013 The Health and Social Care Board issued a letter requesting that all HSC Trusts take appropriate actions in accordance with The Northern Ireland Adverse Incident Centre Estates and Facilities Alert EFA/2010/006. Information in relation to the use of profiling beds was re-issued in March 2015 from the Health and Social Care Board and the Public Health Agency.

During the course of the inspection the inspector noted one profiling bed located within a single bedroom.

The inspector reviewed the care file for the patient that was currently occupying this bed. The inspector noted that there was no clear rationale, care plan or risk assessment included in the patient's files for the use of the profiling bed. The inspector brought this to the attention of the ward manager who agreed to take action on the matter. A recommendation has been made in relation to this.

4.1 Implementation of Recommendations

Eight recommendations which relate to the key question "**Is Care Safe**?" were made following the inspection undertaken on 27 and 28 October 2014.

These recommendations concerned auditing of the safeguarding activity and use of person centred care plans. Provision of staff training in the management of patients' monies, deprivation of liberty, human rights, restrictive practices and capacity to consent, safeguarding of patients monies and the correct completion of comprehensive risk assessments.

The inspector noted that four recommendations had been fully implemented:

- In three of the four patients' files had care plans in place which were person centred regarding deprivation of liberty and restrictive practices.
- Staff had received training in deprivation of liberty, human rights, restrictive practices and capacity to consent.
- Staff were completing comprehensive risk assessments in accordance with Promoting Quality Care guidance.

However, despite assurances from the Trust, four recommendations had not been fully implemented. These included recommendations regarding safeguarding audits, staff training on managing patients' monies, verify of patients' cash statements and weekly checks of patients' monies.

Three recommendations which relate to the key question "**Is Care Effective**?" were made following the inspection undertaken on 27 and 28 October 2014.

These recommendations concerned the availability of completed physical intervention forms, management of leave for occupational therapy staff and staff awareness of the overall purpose and function of the ward.

The inspector was pleased to note that two recommendations had been fully implemented:

- The annual leave for occupational therapy staff was being monitored by the Head OT and the ward manager.
- Staff who met with the inspector were aware of the overall purpose and function of the ward.

However, despite assurances from the Trust, one recommendation had not been fully implemented. This was in relation to the storage of physical intervention forms in patients' notes.

Five recommendations which relate to the key question "**Is Care Compassionate**?" were made following the inspection undertaken on 27 and 28 October 2014.

These recommendations concerned the opportunity for patients to attend their weekly multi-disciplinary meeting, provision of information in relation to the detention and appeals process. The creation of a structured recreational

activity schedule for evenings and weekends and the review of the communal space for female patients.

The inspector noted that four recommendations had been fully implemented:

- A review of four patients' files evidenced that patients had been provided with the opportunity to attend multi-disciplinary team meetings.
- Discussion with patients, the OT and a review of records evidenced the availability of activities in the evenings and at weekends.
- In three of the four patients' files reviewed the inspector noted that patients had been provided with information in relation to the detention and appeals process.
- The inspector noted that the female living area had now relocated to another section of the ward, providing more space for female patients.

However, despite assurances from the Trust, one recommendation had not been fully implemented. This was in relation to the updating of the patient handbook with information regarding the mental health review tribunal.

5.0 Patient Experience Interviews

Four patients agreed to meet with the inspector to talk about their care, treatment and experience as a patient. None of the patients agreed to complete a questionnaire regarding their care, treatment and experience as a patient. The patients who met with the inspector spoke positively regarding the ward. Patients explained to the inspector the range of activities that were available, one patient showed the inspector some of their creative writing that they had completed. Patients who met with the inspector were aware of the detention process and expressed no concerns in relation to their care and treatment

The inspection was unannounced. No relatives or carers were available to meet with inspectors during the inspection.

6.0 Other areas examined

During the course of the inspection the inspector met with:

Ward Staff	4
Other ward professionals	1
Advocates	0

Wards staff

The inspector met with four members of nursing staff during the course of the inspection. Staff who met with the inspector were able to advise the inspector

of the purpose and core function of the ward. Staff who met with the inspector were also able to confirm that they had attended training in consent, human rights, deprivation of liberty and management of patients' monies and a review of the training matrix further clarified this. The inspector spoke with nursing staff regarding the provision of activities for patients. Staff were able to advise the inspector of the range of activities provided particularly in the evenings and weekends. The nursing staff advised the inspector that they had no concerns in relation to the care and treatment of patients on the ward.

Other ward professionals

The inspector met with one of the occupational therapists (OT) for the ward who provided the inspector with an overview of the activities provided by OT on the ward. The inspector also discussed the leave arrangements for OT staff. The OT explained that the team of OT staff ensure amongst themselves that they do not make leave arrangements at the same time. This is monitored and supervised by the Head OT and the ward manager. The OT advised the inspector that they had no concerns in relation to the care and treatment of patients on the ward.

Advocacy services

The inspection was unannounced. No advocates were available to meet with the inspectors during the inspection.

7.0 Next Steps

A Quality Improvement Plan (QIP) which details the areas identified for improvement has been sent to the ward. The trust, in conjunction with ward staff, are required to complete the QIP detailing the actions to be taken to address the areas identified and for return to RQIA by 10 July 2015.

The lead inspector will review the QIP. When the lead inspector is satisfied with actions detailed in the QIP it will be published alongside the inspection report on the RQIA website.

The progress made by the ward in implementing the agreed actions will be evaluated at a future inspection.

Appendix 1 – Follow up on Previous Recommendations
Appendix 2 – Patient Experience Interview

Appendix 1

Follow-up on recommendations made following the announced inspection on 27 and 28 October 2014

No.	Reference.	Recommendations	Number of time stated	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	5.3.1 (c)	It is recommended that the ward manager conducts audits of safeguarding activity.	2	The inspector was informed that the Trust had recently completed a staff questionnaire survey of the adult safeguarding process. The data from the questionnaires had not been collated into a final report. This was waiting to be compiled by the Safeguarding Vulnerable Adult nurse specialist. There was no date available for completion. The inspector spoke with the SVA nurse specialist who advised that this current piece of work did not include an audit of individual ward safeguarding activity. The inspector discussed this recommendation with the ward manager and requested ward specific safeguarding audits. The ward manager was unable to provide this information during or post inspection when requested.	**Not met**
2	7.3.(c)	It is recommended that staff review the use of standardised deprivation of liberty care plans and record exactly what the restrictions exactly and why they are required. Reference should be made to specific Human Rights and reciprocity.	2	The inspector reviewed four patients' care files. The inspector confirmed that in three of the four files reviewed a personalised deprivation of liberty (DoL) care plan was in place with restrictions recorded and reference to respective Human Rights articles. In one of the patients files for a patient who had no care plans, this was not in place. A separate recommendation will be made in relation to this.	**Fully met**
3	5.3.1 (f)	It is recommended that the ward manager ensures there is a copy of the physical intervention form available in	2	The inspector reviewed an incident were the use of physical intervention was required on 8/4/15. This was the only incident in the current accident/incident and near miss book. The inspector reviewed the	**Not met**

		the patient's notes.		records for the patient involved in restraint and noted that the nurse had recorded that a physical intervention form had been completed however this was not attached or included within the patient's notes. This was brought to the attention of the deputy ward manager who also advised that the same form could not be located anywhere on the ward and believed that it may have been with the Nursing Services Manager.	
4	4.3.(m)	It is recommended that the ward manager ensure that all staff attend up to date training in the management of patients' monies and valuables.	2	The inspector reviewed the training matrix for the ward and noted that 6 (23%) of the 26 staff currently working on the ward had no record of having attended this training. The inspector was informed that there were currently no further dates available for staff to attend.	**Not met**
5	4.3 (b)	It is recommended that the ward manager ensures that individual patient statements are received from the cash offices in order to verify that transactions are correct.	2	The deputy ward manager advised the inspector that this practice was still not in place for any of the patients. A copy of the statements were obtained from the cash office by the deputy ward manager by the end of the inspection, however these had not been cross referenced to the ward records of patients' finances.	**Not met**
6	5.3.1 (f)	It is recommended that the ward manager ensures that regular weekly checks of patients' money held against the cash ledger are undertaken and appropriately recorded.	2	The inspector reviewed the patients' account/safe register audit sheets for all patients and noted that weekly checks were not being completed. In the case of three of the 15 patients on the ward there had been no review of their records since February 2015. The deputy ward manager confirmed that these were the only checks currently undertaken. The ward manager confirmed that they had not been completing weekly checks of all patients' records.	**Not met**
7	7.3 (c)	It is recommended that the	1	The inspector reviewed the staff training records for	**Fully met**

		ward manager ensures that all staff receive training in capacity to consent, human rights, restrictive practices and the Deprivation of Liberty Safeguards (DOLS) –Interim Guidance.		the ward and noted that 24 of the 26 staff currently working had a record of having attended the training listed.	
8	7.3.(C)	It is recommended the ward manager ensures that all deprivation of liberty care plans are person centred and linked to patients comprehensive risk assessments. The ward manager should ensure these care plans are completed in accordance with the deprivation of liberty safeguards (DOLS) interim guidance and in accordance with the NHSCT local policy on deprivation of liberty	1	The inspector reviewed four patients care files. The inspector can confirm that in three of the four files reviewed a personalised DoL care plan was in place with exact restrictions recorded and reference to respective Human Rights Articles. In one of the patients files for a patient who had no care plans, this was not in place. A separate recommendation will be made in relation to this.	**Fully met**
9	4.3 (n)	It is recommended the Trust review the current medical input on the ward to ensure all patients are offered the opportunity to attend their weekly MDT meetings	1	A review of four patients' files evidenced patients had been given the opportunity to attend their MDT meetings. Where patients are unable to attend this was recorded. In addition there was evidence of patients being reviewed by their consultant outside of the weekly meeting when required.	**Fully met**
10	5.3.3.(a)	It is recommended that the ward manager ensures that information in relation to the detention process and the	1	The inspector reviewed the patient information handbook. This did not provide information in relation to the MHRT or the detention process. Information in relation to RQIA was also incorrect; this was brought	**Not met**

		mental health review tribunal is included in the patients individual handbook		to the attention of the ward manager.	
11	5.3.1.(a)	It is recommended that the ward manager ensures that all comprehensive risk assessments are completed in accordance with the Promoting Quality Care- Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services	1	The inspector reviewed the Comprehensive Risk Assessment and management tool for four of the 15 patients on the ward and identified no concerns with their completion.	**Fully met**
12	7.3 (a)	It is recommended that the ward manager ensure that occupational therapist's annual leave arrangements are reviewed by their management to ensure adequate cover on the ward	1	The inspector met with the ward based occupational therapist and ward manager who both provided reassurances that the leave of OT staff was now closely monitored by the ward manager and the Head OT. The Head OT had confirmed that they would increase OT provisions on the ward; this was confirmed in discussions between the Head OT and the ward manager. The inspector reviewed emails to that effect.	**Fully met**
13	7.3 (a)	It is recommended that the ward manager develops a structured recreational activity schedule for evenings and weekends which will consider the individual needs and views of the patients.	1	The inspector reviewed the ward activity timetable which was clearly displayed on the ward. The activity timetable included the provision of activities at weekends and in the evenings. The inspector noted in three of the four patients' files reviewed evidence of activities being provided by nursing staff in the evenings and at weekends. Patients who met with the inspector expressed no concerns in relation to the provision of activities.	**Fully met**

14	5.3.3 (a)	It is recommended that the ward manager ensures that all patients who have been detained under the Mental Health (Northern Ireland) Order 1986 have been given information on their rights in relation to the MHRT and the detention process	1	The inspector noted in care files for three patients subject to detention that information had been provided to the patient in relation to the mental health review tribunal and the detention process. This was signed by the registered nurse and the patient, where the patient was unable to sign this was recorded.	**Fully met**
15	6.3.1 (a)	It is recommended that the Trust review the communal space for female patients on the ward	1	The inspector was pleased to note that the female living area had now been relocated to another section of the ward. This provided female patients with two large communal spaces.	**Fully met**
16	4.3 (e)	It is recommended that ward manager ensures that all staff are aware of the overall purpose and function of Carrick 4 ward since it amalgamated with other wards on the hospital site.	1	The inspector reviewed the most recent operational policy for the ward. A review of the policy clearly reflected the purpose and functions of Carrick 4. The inspector met with four members of nursing staff. Staff who met with the inspector were aware of the overall purpose and function of the ward.	**Fully met**

Quality Improvement Plan

Unannounced Follow Up Inspection

Carrick 4, Holywell Hospital

8 & 15 May 2015

The areas where the service needs to improve, as identified during this inspection visit, are detailed in the inspection report and Quality Improvement Plan.

The specific actions set out in the Quality Improvement Plan were discussed with the deputy ward manager and ward manager on the day of the inspection visit.

It is the responsibility of the Trust to ensure that all requirements and recommendations contained within the Quality Improvement Plan are addressed within the specified timescales.

Recommendations are made in accordance with The Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS, 2006.

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
Is Care Safe?					
1	5.3.1 (c)	It is recommended that the ward manager conducts audits of safeguarding activity.	3	27 July 2015	A safeguarding Audit was carried out on the last three months activities, Feb-April 2015 inclusive and also the last three referral have been audited by Ray McCafferty, safeguarding Nurse Specialist. The Ward Manager will audit activity on a 3 monthly basis and record same. Safeguarding continues to be a standing item on the ward business meetings monthly agenda and on the supervision agenda between ward manager and their Line Manager.
2	4.3.(m)	It is recommended that the ward manager ensure that all staff attend up to date training in the management of patients' monies and valuables.	3	10 July 2015	23 staff have been trained The 8 remaining staff have received training using the agreed information and training material provided by the Trust. This was completed on 30/05/15
3	4.3 (b)	It is recommended that the ward manager ensures that individual	3	Immediate	The ward manager receives a copy of each

		patient statements are received from the cash offices in order to verify that transactions are correct.		and ongoing	individual patients statement from the accounts office at the end of each month. A reconciliation of the safe audit, patients accounts and monthly statement is completed and a copy retained in the individuals finance file. This will be checked at supervision between ward manager and Line Manager
4	5.3.1 (f)	It is recommended that the ward manager ensures that regular weekly checks of patients' money held against the cash ledger are undertaken and appropriately recorded.	3	Immediate and ongoing	The ward manager checks the patients monies held in the ward safe against the safe register each week and records same in the cash ledger which is held in the ward.
5	4.3 (i)	It is recommended that the ward manager ensures that all patients who use a profiling bed have a clear rationale in their care records supported by a risk assessment and care plan.	1	Immediate and ongoing	The ward manager completed a profile bed risk assessment on 28/05/15. This is in the service users file A care plan for the use of the low profile bed was completed on 16/5/15 and remains under review.
6	5.3.1 (a)	It is recommended that the ward manager ensures that care plans and risk assessments are completed for all new admissions to the ward within a reasonable timeframe. In the interim a multi-disciplinary interim care plan	1	Immediate and ongoing	All patients have interim care plans completed on admission to the ward and as per operational policy the MDT care plan is completed within two weeks of admission. This is done at the MDT meetings which occur on a weekly basis.

		should be devised.			
		Is Care Effective?			
7	5.3.1 (f)	It is recommended that the ward manager ensures there is a copy of the physical intervention form available in the patient's notes.	3	Immediate and ongoing	The ward manager tabled this item on the agenda for the staff meeting on 03/06/15 The ward manager will monitor same
8	5.3.1 (f)	It is recommended that the trust expedite the replacement or repair of the bath on the ward.	1	10 July 2015	The bath was repaired by outside contractors at end of June 2015.
9	5.3.1 (a)	It is recommended that the ward manager ensures that care plans no longer applicable to patient care are reviewed and subsequently discontinued.	1	Immediate and ongoing	All current care plans are relevant to the patients care at this time and are reviewed at MDT meetings and updated accordingly to reflect the patient's needs. Care plans no longer relevant have been discontinued and filed. The ward Manager conducts a file audit at supervision with each Named and Associate Nurse on a monthly basis.
10	5.3.1 (a)	It is recommended that the ward manager ensures that the integrated care pathway is completed and in place for all patients on the ward.	1	Immediate and ongoing	Integrated Care pathways are in place for all patients from their admission to hospital. Patients who are transferred from other hospitals outside of the Trust have an Integrated Care Pathway completed on admission to Carrick 4

Recommendations are made in accordance with The Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS, 2006.

Is Care Compassionate?					
11	5.3.3.(a)	It is recommended that the ward manager ensures that information in relation to the detention process and the mental health review tribunal is included in the patients individual handbook.	2	10 July 2015	The information in the patients booklet has been updated again to reflect the information that has been requested. This was completed on the 07/07/15. A copy was given to each patient and emailed to the RQIA inspector Kieran McCormick.

NAME OF WARD MANAGER COMPLETING QIP	John Quinn
NAME OF CHIEF EXECUTIVE / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Dr Tony Stevens

Recommendations are made in accordance with The Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS, 2006.

Inspector assessment of returned QIP				Inspector	Date
		Yes	**No**		
A.	Quality Improvement Plan response assessed by inspector as acceptable	X		Kieran McCormick	7 July 2015
B.	Further information requested from provider		X	Kieran McCormick	7 July 2015