# Unannounced Follow up Inspection Report
# 13 December 2017

## Carrick Four

## Psychiatric Inpatient Recovery and Rehabilitation Ward
## Holywell Hospital
## 60 Steeple Road
## Antrim
## BT41 2RJ

## Tel No: 028 9442 3163

## Inspectors: Alan Guthrie and Dr John Simpson

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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

Carrick Four is a 13 bedded ward situated on the ground floor 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 to support patient recovery and rehabilitation.

On the day of the inspection there were 13 patients who had been admitted to the ward. Eleven patients were on the ward at the time of inspection and two patients were on leave. Eight patients were detained in accordance with Mental Health (Northern Ireland) Order 1986.

The ward's multi-disciplinary team incorporates nursing, medical, psychiatry, occupational therapy, social work and clinical psychology.

The ward manager was in charge of the ward on the day of the inspection.

## 3.0 Service details

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| **Responsible person:** Dr Tony Stevens | **Ward Manager:** John Quinn |
| **Category of care:** Psychiatric inpatient recovery and rehabilitation ward | **Number of beds:** 13 |
| **Person in charge at the time of inspection:** John Quinn | |

## 4.0 Inspection summary

An unannounced follow-up inspection of Carrick Four took place on the 13 December 2017.

The purpose of the inspection was to meet with patients and staff and to review the 13 areas for improvement identified from the previous unannounced inspection completed on 19 - 23 October 2015. Findings from the inspection were largely positive. Inspectors evidenced that on the day of the inspection that patients were receiving a good standard of care and that the ward was being well led.

On the day of the inspection inspectors evidenced that the ward was appropriately staffed and the atmosphere was relaxed and welcoming. The ward was clean, fresh smelling and well presented. However, inspectors noted that the ward's design and fixtures and fittings presented a high risk in relation to potential ligature points. Whilst the trust had identified the risks through a ligature risk assessment significant capital was required to remove/replace ligature points. Inspectors were informed that an updated capital bid for a new purpose built facility had been submitted to the Department of Health and that that the original capital bid had been presented to the Department approximately five years ago. The bid was not successful. Given that significant ligature risks remain the area for improvement related to ligatures will be restated for a second time in the quality improve plan (QIP) accompanying this report.

Inspectors noted that three patients had been in hospital for over five years. This included one patient who had been in the hospital for over 24 years. Patients who met with inspectors stated that they were satisfied with the care and treatment they received on the ward. Each of the patients reflected that they knew all of the staff on the ward and that they could approach staff as required.

Staff who met with inspectors stated that the ward was managed appropriately and the care and treatment interventions provided to patients were effective. Staff were positive regarding their involvement with, and the effectiveness of, the ward's MDT. Inspectors reviewed three sets of patient care records and six medical kardexs (record of patients' medications). Generally, records were noted to be comprehensive, up to date and easy to follow. Each patient had a comprehensive assessment, risk assessment and care plan based on their assessed needs. The ward had introduced an updated MDT template. Nursing continuous care records were noted to be appropriately detailed, patient centred and linked to the patient's care plan.

Inspectors reviewed each of the 13 areas for improvement identified as a result of the previous inspection. Inspectors evidenced that the trust had made significant progress in addressing each of the areas. Ten of these areas had been met and three areas had been partially met. Areas for improvement in relation to the ward's governance arrangements, pro re nata (PRN) medication, environmental checks, the management of safeguarding referrals, staff meetings, patient involvement in their care and treatment, staff mandatory training and the management of profiling beds had all been met. The evidence verifying inspectors' findings for each of these areas for improvement is discussed in section 6.1.

Three areas for improvement had been partially met. A ligature risk audit had been completed on the ward on the 13 October 2017. The audit identified a large number of ligature points and associated risks related to the ward's design and fixtures and fittings. The suggested action plan identified that significant works would be required to address the presenting ligature risks. Whilst the trust had submitted a capital bid a schedule of works and related timeline to address the ligature points was not available.

The second area for improvement that was partially met related to patient risk assessments and risk management plans. Inspectors reviewed three sets of patient care and treatment records. Each patient had a comprehensive risk assessment (CRA) completed and these had been updated by staff as required. One CRA had not been signed by the patient or staff. One had not been signed by the patient as they were unable to sign and one had been signed by the patient and staff. The two CRA's that had not been signed by the patient did not include a reason as to why the patient had not signed. This area for improvement will be restated for a second time in the QIP accompanying this report.

The third and final area for improvement which was partially met relates to trust policies. Inspectors evidenced that a number of trust policies were out of date. These included the Hand Hygiene Policy, Uniform and Dress Code policy and the Fire Safety and Arson policy. This area for improvement will be restated for a second time in the QIP accompanying this report.

Inspectors identified one new area for improvement. One patient's CRA had not been managed in accordance to Promoting Quality Care (PQC) guidelines. The patient's CRA had not been reviewed on a six monthly basis. An area for improvement regarding this issue has been made and is detailed in the QIP accompanying this report.

Patients stated

Inspectors met with five patients. Patients presented as being relaxed and at ease in their surroundings and with staff. Each patient reported no concerns at being able to approach staff if something was wrong or they needed support. Patients stated that they were treated with dignity and respect. Inspectors observed patient and staff interactions during the inspection. Staff were evidenced as being supportive, attentive, patient centred and caring. Inspectors observed staff to be available throughout the ward. Patients informed inspectors that they knew who to talk to if they had a concern or were not happy. It is important to note that two patients expressed concerns regarding the length of time they had spent in hospital. Both patients stated that they were keen to move out of the ward and back to their communities. Inspectors reviewed the circumstances for both these patients. Care records evidenced that ward staff and the trust continued to try and secure suitable arrangements for these patients regarding appropriate accommodation, support and care in the community.

Patient comments included:

"Everybody is getting better."

"The ward manager is good."

"I don't feel as safe since my doctor left."

"Staff listen to what I say."

"Some staff are good to me."

"Some staff treat you better than others."

"I can see a doctor when I need too."

"There is plenty of staff on the ward."

"I can spend time with my primary nurse."

Relatives stated

No relatives were available to meet with inspectors on the days of the inspection.

Staff stated

Inspectors met with eight members of ward staff.

Staff who met with the inspector reported that they felt the ward was effective and patient centred. Staff stated that the ward was a positive place to work and that their views and opinions were sought and considered. Staff reported that they felt the MDT was inclusive and care and treatment decisions were discussed. Inspectors noted that the ward was being supported by two temporary locum consultant psychiatrists. Inspectors were informed that this was an interim arrangement due to long-term leave. Inspectors were assured that long-term locum consultant psychiatrist support would be available in the near future. Inspectors noted

that both of the current consultants had settled well into the team. The consultants and ward staff were also being supported by a long term locum staff grade doctor.

Nursing staff who spoke with inspectors stated that they believed the care provided to patients admitted to the ward was safe, effective and compassionate. Staff also felt that the ward was appropriately managed. Staff reported no concerns regarding the levels of nursing staff available. Staff informed inspectors that they had no difficulties regarding their ability to access training and supervision.

Staff comments included:

"There is a good staff skill mix on the ward."

"Staffing levels are generally o.k. on the ward".

"My opinion is listened to and valued".

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 |
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The total number of areas for improvement comprise of three areas being restated for a second time. One new area for improvement was identified as a result of 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

## 6.0 The inspection

The following areas were examined during the inspection:

- Care documentation in relation to four patients
- Ward environment
- Governance arrangements
- Patient discharge/transfer arrangements
- Minutes of staff meetings
- Records in relation to incidents and accidents
- Staff supervision and appraisal dates
- Staff training records
- Incident records
- Staff duty rotas
- Complaints and compliments procedures
- Information in relation to safeguarding vulnerable adults
- Minutes from governance meetings

### 6.1 Review of areas for improvement from the last unannounced inspection

The most recent inspection of Carrick Four was an unannounced inspection. The completed Provider Compliance Plan (PCP) was returned and approved by the responsible inspector. During this inspection inspectors reviewed the areas for improvement made at the previous inspection and an assessment of compliance was recorded as met, partially met or not met. This PCP was validated by inspectors during this inspection.

**Follow-up on recommendations made following the unannounced inspection on 19 – 23 October 2015.**

| Areas for Improvement | | Validation of Compliance |
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| **Number/Area 1**<br><br>**Ref**: 5.3.1 (f)<br><br>**Stated:** First Time | A ligature risk management plan / schedule of works was not available for this ward on the day of inspection. | **Partially Met** |
| | **Action taken as confirmed during the inspection**:<br>A ligature risk audit had been completed on the 13 October 2017. The audit identified a large number of ligature points and associated risks related to the ward's design and fixtures and fittings. The suggested action plan identified that significant works would be required to address the presenting ligature risks. A schedule of works and related timeline were not available. | |
| **Number/Area 2**<br><br>**Ref**: 4.3 (b)<br><br>**Stated:** First Time | Corporate, strategic and local governance mechanisms / arrangements for the review of incidents were not available for this ward. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>Inspectors reviewed the mechanisms for the corporate, strategic and local governance arrangements for the review of incidents that had taken place on the ward. Incidents were recorded on the Trust's DATIX electronic incident recording system. Incidents were referred to the Trust's governance department and being managed in accordance to Trust and regional policy and procedure. The ward's safeguarding officer was involved as required and incidents were reviewed by the ward's multi-disciplinary team (MDT) and the Carrick Four senior management business meeting which was convened quarterly. | |
| **Number/Area 3**<br><br>**Ref**: 5.3.1 (a)<br><br>**Stated:** First Time | Risk assessment and risk management plans had not been signed by the multi-disciplinary team, the patient, or their carer (where appropriate). | **Partially Met** |
| | **Action taken as confirmed during the inspection**:<br>Inspectors reviewed three sets of patient care and treatment records. Each patient had a comprehensive risk assessment (CRA) completed and these had been updated by staff as required. | |

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| | However, one of the records reviewed evidenced that the patient's CRA had not been managed in accordance to Promoting Quality Care (PQC) guidelines. Additionally the patient's CRA had not been reviewed on a six monthly basis.<br><br>Entries to CRA records had been signed by staff. One CRA had not been signed by the patient or staff. One had not been signed by the patient as they were unable to sign and one had been signed by the patient and staff. The two CRA's that had not been signed by the patient did not include a reason as to why the patient had not signed. (New area for improvement). | |
| **Number/Area 4**<br><br>**Ref**: 5.3.1 (f)<br><br>**Stated:** First Time | Indications and the maximum dose for Pro Re Nata (PRN) medication was not always recorded.<br><br>**Action taken as confirmed during the inspection**:<br>Inspectors reviewed six patient medication kardexs (record of medications). Use of PRN medication was noted as being in accordance to clinical need. Prescribing regimes were appropriate and within clinical guidelines. | **Met** |
| **Number/Area 5**<br><br>**Ref**: 5.3.1 (f)<br><br>**Stated:** First Time | There was no action plan in place or date for completion of findings from the environmental / hygiene check.<br><br>**Action taken as confirmed during the inspection**:<br>Inspectors reviewed the ward's patient environment leadership walk around audit (completed 5 May 2017) and the ward's most recent cleaning audit (11 July 2017). The leadership walk around audit included action updates. Inspectors evidenced that the findings from the audit had been addressed. Required actions identified as a result of the hygiene check had also been implemented. | **Met** |
| **Number/Area 6**<br><br>**Ref**: 5.3.2 (a)<br><br>**Stated:** First Time | Vulnerable adult referrals were not recorded as incidents.<br><br>**Action taken as confirmed during the inspection**:<br>Inspectors reviewed the ward's most recent vulnerable adult referrals. Referrals had been recorded as incidents on the Trust's DATIX system. | **Met** |

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| **Number/Area 7**<br><br>**Ref**: 8.3 (d)<br><br>**Stated:** First Time | Staff meetings did not occur every month.<br><br>**Action taken as confirmed during the inspection**:<br>Inspectors reviewed the ward's staff meeting records for the previous six months. Meetings had been held monthly since July and records detailed standing agenda items. These included safeguarding referrals, incidents, training, NMC revalidation and any other business. A team meeting in November was cancelled due to unforeseen circumstances. Inspectors were advised that a meeting for December was scheduled. | **Met** |
| **Number/Area 8**<br><br>**Ref**: 5.3.3 (b)<br><br>**Stated:** First Time | Patients had not signed their occupational therapy assessments and plans.<br><br>**Action taken as confirmed during the inspection**:<br>Inspectors reviewed three sets of patient care records. Each patient had an OT assessment completed which included assessment of the patient's ability to complete a number of functional and personal tasks. Two of the patients had signed their OT assessments and plans. It was noted that one patient had refused to sign. | **Met** |
| **Number/Area 9**<br><br>**Ref**: 5.3.3 (b)<br><br>**Stated:** First Time | It was not consistently recorded that patients were offered one to one time. Staff did not always record if they had spoken to each patient and measured their progress on a daily basis.<br><br>**Action taken as confirmed during the inspection**:<br>Patient care records reviewed by inspectors evidenced that each patient spent one to one time with staff on a daily basis. Records detailed that staff measured patient progress consistently. Records were detailed and completed to a good standard. It is important to note that patients did not always request one to one time with staff when this was offered. | **Met** |
| **Number/Area 10**<br><br>**Ref**: 5.3.1 (f)<br><br>**Stated:** First Time | The multi-disciplinary team ward round template was not always fully completed.<br><br>**Action taken as confirmed during the inspection**:<br>Inspectors reviewed the MDT ward round template | **Met** |

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| | records of three patients. Inspectors reviewed each patient's record for the previous six months. Records evidenced that each template had been completed in full. It was positive to note that nursing staff had also completed a pre-meeting template to ensure patient progress was appropriately monitored and recorded prior to sharing this with colleagues at the MDT ward round. | |
| **Number/Area 11**<br><br>**Ref**: 4.3 (m)<br><br>**Stated:** First Time | Not all staff had received up to date mandatory training in the following areas – Cardio Pulmonary Resuscitation (CPR), Infection Control, Fire Training, COSHH, Manual Handling, Safeguarding Vulnerable adults, and Child Protection. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>Inspectors reviewed the nursing staff record of training and spoke with OT and medical staff. Nurse staff training records evidenced that mandatory training in Safeguarding training, Child Protection, CPR, infection control; fire training and COSHH training was up to date. Mandatory training in moving and handling was not up to date. Inspectors discussed this with the ward manager. The ward manager evidenced that they had previously sought dates for this training. The manager also assured inspectors that this training had been prioritised. Inspectors were satisfied that deficits in manual handling training would be addressed in the near future.<br><br>Medical and OT staff who met with inspectors reported no concerns regarding access to mandatory training. Staff reported that their training was up to date. | |
| **Number/Area 12**<br><br>**Ref**: 5.3.1 (f)<br><br>**Stated:** First Time | Seven out of ten trust policies sent to RQIA prior to inspection were out of date and the Operational Policy for Carrick 4 was available in draft form. | **Partially Met** |
| | **Action taken as confirmed during the inspection**:<br>The ward's operational policy had been completed and was available to staff, patients and relatives. Inspectors evidenced that a number of Trust policies were out of date. These included the Hand Hygiene Policy, Uniform and Dress Code policy and the Fire Safety and Arson policy. | |

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| **Number/Area 13**<br><br>**Ref**: 4.3 (i)<br>**Stated:** Second Time | A clear rationale supported by a risk assessment and care plan was not available for one patient who was using a profiling bed. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>Inspectors reviewed the ward's procedures for the use of profiling beds. Inspectors evidenced that risk assessments and care plans were available for patients who required the use of a profiling bed. Whilst inspectors were concerned that the ward contained a large number of ligature points. The use of profiling beds and associated risks were being assessed and managed. | |

## 7.0 Other areas examined

Inspectors assessed if the ward was being well led using the following indicators.

### Is The Service Well Led?

There is effective leadership, management and governance which create a culture focused on the needs and experiences of patients in order to deliver safe, effective and compassionate care.

**Key Indicator WL1 - There are appropriate management and governance systems in place to meet the needs of patients.**

### Examples of Evidence:

Staff who met with inspectors stated that they understood their role and responsibilities and the actions they should take to safeguard patients and their families.

Incidents had been recorded appropriately and included a description of the circumstances and the action taken.

Patient care records evidenced that safeguarding referrals were appropriately managed and incidents had been recorded and reviewed in line with trust policy and procedure.

There were good working relationships evident between the MDT members.

### Area for Improvement:

A number of the trust's policies were out of date.

**Key Indicator WL2 - There are appropriate management and governance systems in place that drive quality improvement.**

**Examples of Evidence:**

There were appropriate systems in place to record and report incidents, accidents and serious adverse incidents.

Ward environmental assessments were up to date.

The ward's environment was clean, well presented and fresh smelling.

**Area for Improvement:**

None identified.

**Key Indicator WL3 - There is a clear organisational structure and all staff are aware of their roles, responsibility and accountability within the overall structure. There are appropriate supervision arrangements in place.**

**Examples of Evidence:**

Staff understood their role and responsibilities within the ward.

There was a clear management structure identifying the lines of responsibility and accountability.

Staff reported that they had received up to date mandatory training, supervision and appraisal.

**Area for Improvement:**

None identified.

**Key Indicator WL4 - There are effective staffing arrangements in place to meet the needs of the patients.**

**Examples of Evidence:**

Staff shortages were appropriately managed and continually reviewed.

Inspectors evidenced good working relationships between the members of the MDT.

Staff informed inspectors that they felt supported.

**Areas for improvement:**

None identified.

Inspectors identified one new area for improvement as a result of this inspection. The ward's MDT should ensure that patients comprehensive risk assessments (CRA's) are completed in accordance to PQC guidance (2011).

## 8.0 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.

## 8.1 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 Provider Compliance Plan via the Web Portal for assessment by the inspector by 15 February 2018.

| Quality Improvement Plan | |
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| **The responsible person must ensure the following findings are addressed:** | |
| **Area for Improvement No. 1**<br><br>**Ref:** Quality Standard 5.3.1 (f)<br><br>**Stated:** Second time<br><br>**To be completed by:**<br>13 June 2018 | A ligature risk management plan / schedule of works was not available for this ward on the day of inspection. |
| | **Response by responsible person detailing the actions taken:**<br>A Minor Works Proforma has been completed and submitted to the Estates Department for them to review and get costings for the individual jobs. A meeting will then be set up with the Estates Manager to ascertain a schedule of works for these jobs to be completed. |
| **Area for Improvement No. 2**<br><br>**Ref:** Quality Standard 5.3.1 (a)<br><br>**Stated:** Second time<br><br>**To be completed by**:<br>13 January 2018 | Risk assessment and risk management plans had not been signed by the multi-disciplinary team, the patient, or their carer (where appropriate). |
| | **Response by responsible person detailing the actions taken:**<br>The Ward Manager will ensure that all named nurses complete all documentation in the ICP's. A checklist has been developed for all named nurses to complete and this will be audited by the Ward Manager and placed within the ICP. |
| **Area for Improvement No. 3**<br><br>**Ref:** Quality Standard 5.3.1 (f)<br><br>**Stated:** Second time<br><br>**To be completed by**:<br>13 June 2018 | Seven out of ten trust policies sent to RQIA prior to inspection were out of date and the Operational Policy for Carrick Four was available in draft form. |
| | **Response by responsible person detailing the actions taken:**<br>The Operational Policy is completed and has been signed off by Senior Management ,and is now operational.<br>Senior Managers are currently reviewing all Trust policies. These are then sent to the Policy Committee and scrutinised before Goverance update the Policy Library. |
| **Area for Improvement No. 4**<br><br>**Ref:** Quality Standard 5.3.1(a)<br><br>**Stated:** First time<br><br>**To be completed by**:<br>13 March 2018 | The ward's multi-disciplinary team must ensure that each patient's comprehensive risk assessment is completed in accordance to the regional Promoting Quality Care (2011) guidance. |
| | **Response by responsible person detailing the actions taken:**<br>All Comprehensive Risk Assessments have been reviewed by the multi-disciplinary team and are in accordance with the Regional Quality Care (2011) guidance. |

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| **Name of person (s) completing the QIP** | JOHN QUINN | | |
| **Signature of person (s) completing the QIP** | | **Date completed** | 2/3/2018 |
| **Name of responsible person approving the QIP** | DR TONY STEVENS | | |
| **Signature of responsible person approving the QIP** | | **Date approved** | 2/3/2018 |
| **Name of RQIA inspector assessing response** | Alan Guthrie | | |
| **Signature of RQIA inspector assessing response** | | **Date approved** | 21/03/2018 |

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

The Regulation and Quality Improvement Authority

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