The Regulation and Quality Improvement Authority

Unannounced Inspection Report
15 September 2017

Inver 4
Acute Psychiatric Admission
Holywell Hospital
60 Steeple Road
Antrim
BT41 2RJ

Tel No: 028 94413105

Inspectors: Alan Guthrie and Dr John Simpson

www.rqia.org.uk

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

Inver 4 is a 20 bed dementia care ward located in Holywell Hospital. The purpose of the ward is to provide assessment, treatment and care to male and female patients suffering from dementia.

Patients admitted to Inver 4 receive support from a multidisciplinary team (MDT) which includes psychiatry, nursing, social work, psychology, physiotherapy and occupational therapy. Dietetics, dentistry and speech and language services are also available on the ward when referred.

On the day of the inspection there were 12 patients on the ward. Four patients had been admitted to the ward in accordance with The Mental Health (Northern Ireland) Order 1986.

3.0 Service details

Responsible person: Mr. Tony Stevens	**Position:** Chief Executive
Person in charge at the time of inspection: Karen Graham - Ward Manager	

4.0 Inspection summary

An unannounced inspection took place on the 15 September 2017.

The inspection was undertaken in response to concerns received by RQIA from a telephone caller. The concerns raised related to the following allegations:

1. The ward's discharge planning was poor and did not fully consider the needs of the patient or their family.
2. The transition arrangements for patients moving from the ward to the community were not appropriate.

Specific methods/processes used in this inspection included the following:

- Discussions with nursing, social worker, management and the consultant psychiatrist.
- Examination of three sets of discharge plans within patient care records.
- Review of the ward's discharge procedures.

Any other information received by RQIA about this service and the service delivery was also considered by inspectors in preparing for this inspection.

Inspectors met with seven members of staff. This included three nursing staff, the social worker, the ward manager, the consultant psychiatrist and a community liaison member of staff.

On arrival to the ward the inspectors met with the ward manager to inform them of the nature of the allegations which had been received by RQIA. On the day of the inspection Inver 4 was evidenced as being calm and relaxed. The inspectors observed that there was an appropriate number of staff available to support patients. Findings in relation to the allegations are discussed below.

4.1 Inspection outcome

Inspectors examined the ward's situation in relation to each of the allegations made by the caller. The nature of the allegations and the inspectors findings are detailed below.

Allegation 1 - The ward's discharge planning was not to the required standard and did not fully consider the needs of the patient or their family.

The inspectors reviewed three sets of patient care documentation. Records were evidenced as being appropriately detailed. Each patient had a risk assessment, an admission checklist, a care plan, records of continued multidisciplinary team (MDT) review and up to date continuing care records. Each patient's MDT record included a review of the patient's progress, an assessment as to the patient's suitability for discharge and identification of an agreed residential/nursing care provider within the community.

Nursing and medical care assessments were appropriately detailed and provided comprehensive over-view of each patient's progress. Inspectors evidenced that relatives and carers were involved in the admission process and family meetings had been updated regarding each patient's progress. Inspectors reviewed the ward's discharging planning processes. Staff who met with inspectors explained that when a patient was ready for discharge the following process was implemented:

1. The MDT assesses and agrees that the patient is ready for discharge and this is supported by evidence of the patient's progress and positive response to treatment.
2. The MDT discusses the patient's progress with the patient's family and commences implementing the discharge plan.
3. A discharge planning meeting is held involving the MDT, family and community teams.
4. A discharge plan is agreed by all parties. This includes a transition plan and discharge date.
5. The patient is discharged from the ward and ward staff continue to liaise with the care provider and the associated community team.

The patient care records reviewed, evidenced that each of the patients discharge planning was being managed in accordance to the ward's process, the standards required by the Trust and in a manner that was patient centred. However, inspectors reviewed one set of care records related to a patient who had previously been admitted to the ward in early 2017. These records evidenced that the ward's discharge procedures had not been fully implemented during the patient's discharge from hospital on the 26 May 2017. The patient was initially discharged for a trial period prior to being discharged permanently to the care of residential home on the 9 June 2017.

The patient's care records evidenced that the patient's discharge had been discussed with their relative. The relative had been involved in the patient's discharge planning and regular contact with the relative had been maintained by the ward's MDT. Prior to the patient leaving the ward a discharge assessment summary was completed. Records detailed that the following professional reports were completed:

- Medical discharge summary was completed on the 24 May 2017.
- A nursing discharge summary was completed on the 18 May 2017.

- An occupational therapy discharge assessment was completed on the 25 May 2017.
- A physiotherapy assessment was completed on the 22 May 2017.
- A social work assessment was also completed. However, there is no date on the report and the completion of the social work report is not recorded on the discharge assessment summary.

Whilst the social work report was not dated and had not been recorded as complete on the patient's discharge assessment summary, a care plan and capacity and financial assessment were completed on the 25 May 2017. Records reviewed by inspectors suggested that the social work report had been completed on the 25 May 2017 prior to the patient's discharge.

There was evidence of continued liaison with the patient and their relative leading up to the patient's discharge. However, continuing care records evidenced that in the two weeks prior to the patient's discharge there were communication issues with the relative. Entries within the continuing care records detailed that a final discharge meeting between the ward's MDT staff, the patient's relative and the residential care provider did not take place as is established practice. The meeting had been organised but was cancelled at short notice due to staff being unavailable (unforeseen circumstances). A follow up appointment between the consultant psychiatrist and the patient's relative had been arranged post discharge however; this meeting did not take place as the relative was unable to attend. The patient was discharged permanently from the ward on the 9 June 2017. Whilst an appointment between the relative and the consultant psychiatrist had been arranged for the 9 June 2017 the patient's relative had been unable to attend. Subsequently, the patient's relative had been unable to meet with the ward's MDT prior to the patient's trial placement and subsequent discharge from the ward.

It is important to note that staff within the ward's MDT continually provided information and reassurances to the patient and their relative prior to the patient's discharge from hospital. This was consistently evidenced in the patient's continuing care records. Inspectors also evidenced that on two occasions staff had recorded that the patient's relative expressed concerns that the patient's discharge from hospital 'felt rushed' (noted social work care record 25/05/2017 and nursing care record 26/05/2017). It was noted that the patient's relative had also been asked to review and sign the patient's discharge plan on the 26 May 2017. Whilst it is understandable that a relative may be anxious and concerned about a patient's discharge, opportunities to further address these concerns did not take place. The MDT had to cancel the last pre-discharge meeting due to unforeseen circumstances, and the relative had been unable to attend the appointment arranged by the consultant psychiatrist on the 9 June 2017.

Evidence reviewed by inspectors detailed that the ward's MDT had undergone a change in consultant psychiatrist on three occasions between February 2017 and May 2017. Inspectors noted no concerns regarding the treatment provided to patients during this period. Staff who met with inspectors stated that the changes in consultant psychiatrist had impacted on consistency and continuity for patients and their families. Whilst staff reported that treatment regimens and the quality of care provided on the ward were not affected a few patients, and their families, had had to meet with three different consultant psychiatrists. This had impacted on the relationships between patients, their relatives and the consultant psychiatrists.

The allegation that the ward's discharge planning was not to the required standard and did not fully consider the needs of the patient was not substantiated. On the day of the inspection inspectors evidenced that the MDT in Inver 4 were managing the discharge of patients in accordance to the required standards. A consultant psychiatrist is now permanently in post

within the ward. It was positive to note that discharge plans reviewed by inspectors were of a high standard. However, the allegation that the ward did not fully consider the needs of the family was partially substantiated. There was evidence that the discharge of one patient in May 2017 had not been completed in accordance to the trust's standards. The last pre-discharge planning meeting had been cancelled and there was limited opportunity to further address the relative's concerns. Whilst the ward's MDT had planned to discharge the patient in accordance to the trust's standards this did not take place due to unforeseen circumstances. A follow up appointment organised by the consultant psychiatrist with the patient's relative was not attended by the patient's relative. Subsequently, the patient's relative did not have an opportunity to address their concerns as recorded by a social worker (25/05/2017) and a nurse (26/05/2017). An area for improvement in relation to this issue has been made.

Allegation 2 – The transition arrangements for patients moving from the ward to the community were not appropriate.

Patient's care records reviewed by inspectors evidenced that each patient's discharge plan continued to be discussed and reviewed with the patient and their relative's. Relatives were involved in the patient's discharge planning and regular contact with relatives continued to be maintained by the ward's MDT. Inspectors also evidenced that the ward had introduced the John's campaign model of care. The emphasis of this model is to ensure the continued involvement of relatives within the ward and to enhance care and treatment for each patient. The integration of this initiative evidences the MDT's desire to provide an open and transparent ward culture and to work in partnership with patients and their relatives/carers. The John's campaign ethos includes flexible visiting times and increased contact and communication between staff and relatives. Inspectors noted that in each of the three files reviewed there was a discharge assessment summary report. One patient was ready for discharge and the summary report had been completed. The remaining two patients were not ready for discharge and the discharge summary had not been completed although a blank report was available in each file. Continued review and assessment of each patient's readiness for discharge was evidenced in MDT meeting minutes, continuing care records and within each patient's care plan.

Discharge planning arrangements for the patient ready to be discharged were reviewed. The arrangements in place for the patient were comprehensive and in keeping with trust standards. The patient's discharge planning summary had been appropriately completed and was in the process of being finalised. Transition arrangements were in place and the patient's family and the community care provider had been involved throughout the discharge planning process. Inspectors evidenced no concerns regarding the transition arrangements for this patient.

Transition arrangements for the individual who had previously been discharged on the 26 May 2017 were not in place as the patient was not ready for discharge. Inspectors reviewed the discharge arrangements implemented for this patient on 26 May as discussed in allegation one. The patient's discharge assessment summary had been completed and the patients care plan had been agreed and reviewed with the patient's relative on the 26 May 2017. This was prior to the patient leaving the ward on a two week trial basis.

Inspectors have forwarded the transition arrangement concerns expressed by the caller (allegation 2) to the inspector responsible for the facility to which the patient was discharged. The responsible inspector will review this allegation with the facilities management team through inspection processes. The allegation that the transition arrangements for patients

moving from the ward to the community were not appropriate was not substantiated from the ward's perspective. Whilst communication concerns regarding contact between the ward's MDT and the patient's relative have been discussed, and an area for improvement identified, the ward's MDT had followed the ward's protocols in managing the patient's discharge on the 26 May 2017. However, opportunities to engage with the patient's relative prior to the patient's discharge did not take place due to unforeseen circumstances. Inspectors noted evidence that ward staff did reassure the relative on a number of occasions. Despite this the patient care records detail that opportunities for the relative to discuss their concerns in person did not take place. This was due to the fact that the last pre-discharge meeting had been cancelled and the relative had been unable to attend the appointment arranged by the consultant on the 9 June 2017.

Areas for improvement

1. The Trust should ensure that should a pre-discharge meeting have to be cancelled due to unforeseen circumstances a further meeting should be reconvened as soon as possible and prior to the patient's discharge.

Total number of areas for improvement	1

5.0 Areas for improvement

This section outlines recommended actions, to address the areas for improvement identified. They promote current good practice and if adopted by the responsible person may enhance service, quality and delivery.

5.1 Actions to be taken by the service

The provider compliance 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 webportal by 10th November 2017.

Provider Compliance Plan **Inver 4**	
Priority 1	
Area for Improvement No. 1 **Standard:** **Stated:** First time **To be completed by:**	The Trust should ensure that should a pre-discharge meeting have to be cancelled due to unforeseen circumstances a further meeting should be reconvened as soon as possible prior to the patient's discharge. **Response by responsible person detailing the actions taken:** The ward social worker will be responsible for organising pre-discharge planning meetings, but in the event that the ward social worker is not available due to, for example annual leave, the person organising pre-discharge planning meetings will be the named nurse for the particular service user, and if this is not possible it will be the nurse in charge.

Name of person completing the provider compliance plan	Patricia Heatley		
Signature of person completing the provider compliance plan	Patricia Heatley	**Date completed**	16/11/17
Name of responsible person approving the provider compliance plan	Dr Tony Stevens		
Signature of responsible person approving the provider compliance plan	Tony Stevens	**Date approved**	22/11/17
Name of RQIA inspector assessing response	Alan Guthrie		
Signature of RQIA inspector assessing response	Alan Guthrie	**Date approved**	27/11/2017

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