The Regulation and Quality Improvement Authority

RQIA

Mental Health and Learning Disability

Unannounced Inspection

Lissan 1

Holywell Hospital

Northern Health & Social Care Trust

2 & 3 September 2014

npm national preventive mechanism

informing and improving health and social care
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Contents

1.0 General Information

Ward Name	Lissan 1
Trust	Northern Health & Social Care Trust
Hospital Address	Holywell Hospital 60 Steeple Road Antrim BT41 2RJ
Ward Telephone number	028 94465211
Ward Manager	Wilma Thom
Email address	wilma.thom@northerntrust.hscni.net
Person in charge on day of inspection	Wilma Thom
Category of Care	Mental Health
Date of last inspection and inspection type	23 May 2014, Patient Experience Interviews
Name of inspector(s)	Audrey Woods Siobhan Rogan

2.0 Ward profile

Lissan 1 is a psychiatric intensive care unit (PICU) located on the Holywell Hospital site. The ward has nine beds and provides care and treatment for male patients. On the day of the inspection there were seven patients on the ward. All seven patients were detained in accordance with the Mental Health (Northern Ireland) Order 1986.

The ward is supported by a multi-disciplinary team that includes a consultant psychiatrist, medical staff, nursing staff, a social worker, occupational therapy, an occupational therapy assistant and advocacy services.

The main entrance door to the ward was locked and the area was monitored by CCTV. Access to the ward was gained via a buzzer system. The ward's office was situated bedside the ward's foyer.

3.0 Introduction

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of Northern Ireland's health and social care services. RQIA was established under the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, to drive improvements for everyone using health and social care services. Additionally, RQIA is designated as one of the four Northern Ireland bodies that form part of the UK's National Preventive Mechanism (NPM). RQIA undertake a programme of regular visits to places of detention in order to prevent torture and other cruel, inhuman or degrading treatment or punishment, upholding the organisation's commitment to the United Nations Optional Protocol to the Convention Against Torture (OPCAT).

3.1 Purpose and Aim of the Inspection

The purpose of the inspection was to ensure that the service was compliant with relevant legislation, minimum standards and good practice indicators and to consider whether the service provided was in accordance with the patients' assessed needs and preferences. This was achieved through a process of analysis and evaluation of available evidence.

The aim of the inspection was to examine the policies, procedures, practices and monitoring arrangements for the provision of care and treatment, and to determine the ward's compliance with the following:

- 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.

Other published standards which guide best practice may also be referenced during the inspection process.

3.2 Methodology

RQIA has developed an approach which uses self-assessment, a critical tool for learning, as a method for preliminary assessment of achievement of the inspection standards.

Prior to the inspection RQIA forwarded the associated inspection documentation to the Trust, which allowed the ward the opportunity to demonstrate its ability to deliver a service against best practice indicators. This included the assessment of the Trust's performance against an RQIA Compliance Scale, as outlined in Section 6.

The inspection process has three key parts; self-assessment, pre-inspection analysis and the visit undertaken by the inspector.

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

- analysis of pre-inspection information;
- discussion with patients and/or representatives;
- discussion with multi-disciplinary staff and managers;
- examination of records;
- consultation with stakeholders;
- file audit; and
- evaluation and feedback.

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

The recommendations made during previous inspections were also assessed during this inspection to determine the Trust's progress towards compliance. A summary of these findings are included in section 4.0, and full details of these findings are included in Appendix 1.

An overall summary of the ward's performance against the human rights theme of Autonomy is in Section 5.0 and full details of the inspection findings are included in Appendix 2.

The inspectors would like to thank the patients and staff for their cooperation throughout the inspection process.

4.0 Review of action plans/progress

An unannounced inspection of Lissan 1 was undertaken on 2 & 3 September 2014.

4.1 Review of action plans/progress to address outcomes from the previous inspection

The recommendations made following the last inspection on 12 and 13 December 2011 were evaluated. The inspector was pleased to note that 18 of the 19 recommendations had been fully met and compliance had been achieved in the following areas:

- Patients can meet their consultant in private
- An outside area is available for patients
- All staff have received up to date training on safeguarding vulnerable adults and this training is included in the wards induction procedures.
- Incidents are reported to patients next of kin when consent is gained from patients
- Patients who require a comprehensive risk assessment have one in place
- Patients can access all bathrooms and toilets on the ward
- Information on patients right to access information and how to make a complaint was available on the ward
- Information in relation to children visiting the ward was available for visitors and patients.
- A policy was in place regarding the admission of patients under the age of 18 on to the ward which reflected immediate safeguards that are put in place
- Environmental changes to promote patient privacy had been made in the seclusion area

Compliance with one recommendation was not assessed as part of this inspection.

4.2 Review of action plans/progress to address outcomes from the patient experience interview inspection

The recommendation made following the patient experience interview inspection on 6 December 2013 were evaluated. The inspector was pleased to note that this recommendation had been fully met and compliance had been achieved in the following area:

- Information is available on the ward on the advocacy service

4.3 Review of action plans/progress to address outcomes from the previous finance inspection

The recommendations made following the finance inspection on 2 January 2014 were evaluated. The inspector was pleased to note that one of the two

recommendations had been fully met and compliance had been achieved in the following areas:

- A system had been put in place to record purchases made by staff on behalf of patients with related receipts.

However, despite assurances from the Trust one recommendation had not been met. One recommendation will require to be restated in the Quality Improvement Plan (QIP) accompanying this report.

5.0 Inspection Summary

Since the last inspection inspectors found that progress had been made in a number of areas in relation to patient's care and treatment on the ward. It was good to note that patients now have access to a full-time occupation therapist and an assistant therapist. There was evidence of individual programmes set up for patients which were either ward based programmes, hospital based programmes or community programmes depending on each patient's individual assessment.

A newly refurbished large outdoor enclosed area was available for patients on the ward which consisted of a seated area with flowers beds and an outdoor five-a-side football pitch.

There was evidence that vulnerable adult referrals are completed immediately after an incident has taken place and forwarded to the designated officer. Training files on the ward evidenced that 100 % of staff on the ward have undertaken training in the protection of vulnerable adults. Inspectors found that staff were aware of their roles and responsibility in relation to safeguarding vulnerable adults.

All patients who required a comprehensive risk assessment had one in place and these were reviewed and updated by the multidisciplinary team**.**

Environmental enhancements had been made to the ward to promote patient privacy and dignity.

The following is a summary of the inspection findings in relation to the Human Rights indicator of Autonomy and represents the position on the ward on the days of the inspection.

It was good to note that there was evidence throughout the care documentation reviewed that the multidisciplinary team had considered patients human rights in relation to article 3, 5, 6, 8 and 10. Staff were able to demonstrate their understanding of the human rights legislation and the implications of this when working with patients on the ward.

Inspectors reviewed care documentation and there was evidence that initial assessments were completed using the Integrated Care Pathway (ICP). This assessment process commenced within two hours of the patient being

admitted onto the ward. The clinical team responsible for the patient's care commenced their assessment of the patients' needs and from this a care and treatment plan was developed.

There was evidence in the care documentation reviewed that patient's capacity to consent to care and treatment was assessed and monitored closely by nursing staff on an ongoing basis and reviewed weekly by the multi-disciplinary team (MDT). Care records reviewed by inspectors evidenced that nursing staff continually monitored patient's progress and recorded any concerns or changes in presenting behaviour.

Inspectors reviewed three sets of care documentation. Inspectors found that patients had the opportunity to discuss their care and treatment with nursing staff on a daily basis. Entries in the care documentation evidenced patients' progress throughout their admission and collaborative work undertaken with patients, carers and relatives.

On arrival to the ward patients received a ward information pack. This pack contained relevant information for each patient on the ward. The ward also had a comprehensive visitor information booklet.

Inspectors noted that the management of the patient by the multi-disciplinary team was an ongoing daily process coordinated by the weekly multi-disciplinary ward round. A multidisciplinary professional meeting was held to discuss each individual patient's progress in advance of the ward round. The multidisciplinary team (MDT) ward round was held each week and each patient was given the opportunity to attend and participate in a discussion regarding all aspects of their care and treatment. Patient care plans and risk assessments were reviewed and updated after the MDT ward round and management/action plans were developed and implemented.

Inspectors noted that patients on the ward do not have access to input from psychology. This was discussed with the ward manager, the acting services manager and the Head of Mental Health Acute Hospital Services at the feedback meeting. Inspectors were informed by the Head of Mental Health Acute Hospital Services that funding had been approved for psychology input for patients on the ward and this service should become available to patients on the ward by early 2015. A recommendation has been made in relation to this**.**

Care notes reviewed by the inspectors evidenced that risk assessments were reviewed and updated on a weekly basis. Inspectors found that care plans were available in the three sets of care documentation reviewed in relation to aspects of patient care to include deprivation of liberty, mental health order rights, think child, think parent, think family and special observations. However, inspectors noted that care plans were not individualised and had not been developed to specifically address individual assessed needs but instead were generic core care plans. The patient centred, individualised care as delivered on the ward on the days on the inspection and recorded in the

continuous care notes was not reflected in the core care plans reviewed by inspectors. A recommendation has been made in relation to this.

The ward had a de-briefing system in place whereby twice a day patient care was discussed with all staff working on the ward including the occupational therapist and social worker.

On the days of the inspection inspectors undertook a direct observation of the ward. Inspectors noted that interactions between the staff and patients were responsive, appropriate and respectful.

Inspectors met with the occupational therapist who works with patients on the ward on a full time basis. The occupational therapist outlined the varied therapeutic and recreational programme of activities available to the patients on the ward. The occupational therapist contributed to the multidisciplinary ward round each week and the daily de-briefing when available. Inspectors noted that the occupational therapist was fully integrated into the multidisciplinary team. Good communication networks were in place to ensure that the occupational therapist was aware of each patient's presentation and aware of any changes made regarding the plan of care or risk management plan. When discussing the occupational therapy programme on the ward with the ward manager and staff on the ward it was clear that the occupational therapist on the ward had made a significant contribution to the care and treatment available to patients and appeared to be very proactive and innovative in their approach with the main focus of patients making a full recovery.

All of the patients on the ward on the days of the inspection were subject to detention under the Mental Health (Northern Ireland) Order 1986. This was discussed at the ward round and by the nursing staff and the medical team when Mental Health (Northern Ireland) Order 1986 prescribed forms were initially signed. Patients could meet with the nursing staff and the consultant to discuss their rights.

Patients could also avail of the advocacy service on the ward and meetings were held with the advocate each week with minutes taken which were then discussed with the ward manager.

Due to the nature of the ward and associated risks, patients on the ward are subject to certain restrictions including a locked entrance door. In spite of this, inspectors noted that staff working on the ward promoted the least restrictive approach to care delivery through a variety of measures such as ensuring that internal doors in the ward remain unlocked so that patients could move freely throughout the ward.

Patients' deprivation of liberty was discussed with the ward manager who stated that discussions take place on a daily basis at ward level regarding reducing restrictions for each individual patient. The ward manager stated that this is monitored closely and staff continually move towards reducing restrictions and this is reflected in the patients care documentation.

The ward manager stated that there were no patients on the Lissan1 who were delayed in their discharge from hospital. Inspectors reviewed care documentation in relation to three patients and noted that care planning focused on moving towards recovery and discharge. Discharge planning and considerations were discussed with the patient and the multidisciplinary team at the weekly ward round.

Inspectors noted that the patient's article 8 rights to respect for private and family life was considered as part of discharge planning. This was evidenced through the involvement of the patient and their relative/carer in the care documentation.

Details of the above findings are included in Appendix 2.

On this occasion Lissan 1 has achieved an overall compliance level of compliant in relation to the Human Rights inspection theme of "Autonomy".

6.0 Consultation processes

During the course of the inspection, the inspector was able to meet with:

Patients	**0**
Ward Staff	**3**
Relatives	**0**
Other Ward Professionals	**2**
Advocates	**0**

Patients

On the days of the inspection none of the patients wished to speak with the inspectors

Relatives/Carers

The inspection was unannounced. There was one relative on the ward who was given the opportunity to meet with the inspectors however they declined.

Ward Staff

The inspectors spoke with three ward staff who all commented that they enjoyed working on the ward and felt well supported. All of the staff stated that their mandatory training was up to date. They had no concerns regarding staffing levels and they all felt that the wards multi-disciplinary team worked well together with a clear focus at each meeting on reviewing patients care, upholding patients rights' and reviewing restrictive practices.

Other Ward Professionals

The inspector spoke with two other professionals who visit the ward. Professionals stated they felt supported within the multi-disciplinary team and enjoyed working on the ward. They stated that they felt patients were provided with a good level of care on the ward and they were very complimentary about the wards comprehensive activity programme in place for each patient.

Advocates

On the day of the inspection the advocate was not on the ward

Questionnaires were issued to staff, relatives/carers and other ward professionals in advance of the inspection. The responses from the questionnaires were used to inform the inspection process, and are included in inspection findings.

Questionnaires issued to	Number issued	Number returned
Ward Staff	20	13
Other Ward Professionals	5	4
Relatives/carers	7	0

Ward Staff

Thirteen questionnaires were returned by ward staff in advance of the inspection. Information contained within the questionnaires demonstrated that staff were aware of the Deprivation of Liberty Safeguards (DOLS) interim guidance. All staff who returned their questionnaires stated they had not received training in areas of Human Rights and capacity to consent. All staff were aware of restrictive practices on the ward. Examples of restrictive practice as reported by staff included "seclusion room, locked unit, patients who are detained and physical interventions".

Staff indicated in their returned questionnaires that they were aware of alternative methods of communication used the on the ward and that the ward had processes in place to meet each patients individual communication needs

Other Ward Professionals

Four questionnaires were received from the Assistant Director of Nursing, the Acting Nursing Service Manager, a Clinical Nurse and the ward advocate. All four professional stated they had received training on human rights, however only one professional stated they had received training on capacity to consent. All four professionals stated they were aware of the deprivation of liberty safeguards (DOLS) –interim guidance and three reported that they had received training in this area

All four staff indicated they were aware of restrictive practices used on the ward. Three staff indicated they were aware of alternative communication methods being used on the ward and were aware of the process in place to meet the needs of patients individual communication needs. One staff member did not answer this section of the questionnaire.

Relatives/carers

No questionnaires were returned from relatives/carers

7.0 Additional matters examined/additional concerns noted

Complaints

Inspectors reviewed complaints received by the ward between the 1 April 2013 and the 31 March 2014. There were fifteen complaints raised with the advocate on the ward and all fifteen complaints were dealt with at local level and recorded as resolved to the satisfaction of the complainant. Information

on how to make a complaint was available throughout the ward and in the wards information booklet. Complaints received were in relation to medication, issues with staff, ward facilitates, ward leave and diagnostic issues. The inspectors noted the complaints were dealt with in accordance with policies and procedures.

Use of Profiling Beds/Exposed Mental Bed Frames on the Ward

Following the letter of 28 February 2014 from The Health and Social Care Boards and Public Health Agency to all Health and social care Trusts regarding the use of profiling beds/exposed mental bed frames within inpatient mental health settings, and the reissue of a safety alert on 23 December 2013 by the Northern Ireland Adverse Incident Centre (NIAIC) – EFA/2010/006 safety alert self-harm associated with profiling beds, inspectors were concerned to note that beds with exposed metal frames continued to be available on the ward in the absence of documented clinical need to support their continued use. Inspectors were also concerned that staff working on the ward were not aware of this safety alert. This was raised with the ward manager, the acting services manager and the Head of Mental Health Acute Hospital Services. The Head of Mental Health Acute Hospital Services advised that a supplier for new beds for the ward had been identified and that all beds would be replaced on the ward in the coming weeks. Recommendations have been made in relation to this.

8.0 RQIA Compliance Scale Guidance

Guidance - Compliance statements		
Compliance statement	**Definition**	**Resulting Action in Inspection Report**
0 - Not applicable	Compliance with this criterion does not apply to this ward.	A reason must be clearly stated in the assessment contained within the inspection report
1 - Unlikely to become compliant	Compliance will not be demonstrated by the date of the inspection.	A reason must be clearly stated in the assessment contained within the inspection report
2 - Not compliant	Compliance could not be demonstrated by the date of the inspection.	In most situations this will result in a requirement or recommendation being made within the inspection report
3 - Moving towards compliance	Compliance could not be demonstrated by the date of the inspection. However, the service could demonstrate a convincing plan for full compliance by the end of the inspection year.	In most situations this will result in a recommendation being made within the inspection report
4 - Substantially Compliant	Arrangements for compliance were demonstrated during the inspection. However, appropriate systems for regular monitoring, review and revision are not yet in place.	In most situations this will result in a recommendation, or in some circumstances a recommendation, being made within the Inspection Report
5 – Compliant	Arrangements for compliance were demonstrated during the inspection. There are appropriate systems in place for regular monitoring, review and any necessary revisions to be undertaken.	In most situations this will result in an area of good practice being identified and being made within the inspection report.

Appendix 1 – Follow up on Previous Recommendations

The details of follow up on previously made recommendations contained within this report are an electronic copy. If you require a hard copy of this information please contact the RQIA Mental Health and Learning Disability Team:

Appendix 2 – Inspection Findings

The Inspection Findings contained within this report is an electronic copy. If you require a hard copy of this information please contact the RQIA Mental Health and Learning Disability Team:

Contact Details
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