The Regulation and Quality Improvement Authority

Inspection Report

08 November – 8 December 2022

Belfast Health and Social Care Trust

Clare Ward
Knockbracken Health Care Park
Saintfield Road
Belfast
BT8 8HB

Tel No: 02890638448

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation/Registered Provider: Belfast Health and Social Care Trust (BHSCT)	**Responsible Individual:** Dr. Cathy Jack Chief Executive, BHSCT
Person in charge at the time of inspection: Ms Tricia Davies-Storer, Ward Manager, Clare Ward	**Number of registered places:** 16
Categories of care: Rehabilitation and Recovery	**Number of patients accommodated in the ward on the day of this inspection:** 16
Brief description of the accommodation/how the service operates: Clare ward is a 16 bedded mixed gender ward providing care and treatment to adults aged 18 years and over who require high dependency rehabilitation in an inpatient mental health ward environment. The ward is situated within the grounds of Knockbracken Healthcare Park and is a single storey unit which consists of single occupancy ensuite bedrooms. Patients are admitted either on a voluntary basis or detained in accordance with the Mental Health (Northern Ireland) Order 1986 (MHO).	

2.0 Inspection summary

An unannounced inspection of Clare ward commenced on 08 November 2022 at 09:00 and concluded on 08 December 2022, with feedback to the Trust's Senior Management Team and representatives of the Multidisciplinary Team. The inspection team comprised of care inspectors, an assistant director and administration staff.

The inspection focused on the following eleven key themes; patient flow; incident management and adult safeguarding (ASG); environment; restrictive practices; patient and relative experience; care and treatment; staffing arrangements and; governance and leadership.

Areas of good practice were noted in relation to the environment, staff induction and adult safeguarding training, incident management and Adult Safeguarding, and patient engagement.

Relatives spoke highly of the nursing and medical staff and were very complimentary about the care their loved one received.

The previous inspection of the ward on 19 September 2017 resulted in three areas for improvement (AFI). These AFIS were reviewed during this inspection and assessed as met.

Intelligence received by RQIA since the last inspection related to concerns about safeguarding in respect to patient monies. This has been managed within the Serious Adverse Incident (SAI) process and in conjunction with the patient's wishes.

Three new AFIs were identified. These are in relation to environmental repairs, patient risk assessments for the use of profiling beds, and staff training.

This inspection did not result in Enforcement Action.

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how they were performing at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

4.0 What people told us about the service

Posters and easy read leaflets were placed throughout wards inviting staff and patients to speak with inspectors and feedback on their views and experiences.

We spoke with two patients, three relatives, and a number of staff. There were no patient or staff questionnaires returned.

Patients who spoke to us indicated they were satisfied with the care and treatment they received and were happy with the staff delivering it.

Staff spoke positively about the ward, the care and treatment for patients, and the leadership/management of the ward.

Opportunities to speak with relatives directly during the course of the inspection were limited as a result of the Covid-19 visiting restrictions; consequently, we sought consent to contact patient relatives and were supported by ward staff to make direct telephone contact. Three relatives/ NOK availed of this opportunity and provided views based on their experiences of visiting the ward. All relatives expressed high levels of satisfaction with the standard of care provided and spoke positively about the staff delivering it.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

The last inspection to Clare ward was undertaken on 19 September 2017; three areas for improvement were identified.

Areas for improvement from the last inspection on 18 September 2017		
The responsible person must ensure the following findings are addressed:		**Validation of compliance**
Area for Improvement No. 1 **Ref:** Quality Standard 5.3.1 (a) **Stated:** Second time **To be completed by:** 19 October 2017	There were inconsistencies on the standard and thoroughness of care plans. One patient had two care plans in place. There were at least two further care plans which required to be updated. One on smoking cessation and one was required in relation to the management of the patient's heart failure. One care plan for diabetes did not include sufficient detail in relation to monitoring blood sugars level and there was no reference to the normal ranges for the patient and what to do if results went above or below acceptable/normal levels. Another patient had 12 care plans which were very thorough and comprehensive. One patient's moving and handling assessment did not have the most important part of the assessment completed. Dates of when this assessment was completed and reviewed were noted though they were not recorded in the correct place.	**Met**
	Action taken as confirmed during the inspection: Since the last inspection the patient care documentation is recorded on PARIS (the Trust electronic recording system). Care plans reviewed by inspectors were detailed, personalised and of good quality. There were no inconsistencies in recording and care plans were in place to address each patients assessed needs. This AFI has been met.	

Area for Improvement No. 2 **Ref:** Quality Standard 6.3.2 **Stated:** First time **To be completed by**: 19 December 2017	The Trust must ensure that patients can access the ward's people carrier car as required.	**Met**
	Action taken as confirmed during the inspection: The Ward Manager advised the ward vehicle is used regularly and is available to all patients where suitable and following risk assessment. The vehicle is driven by the majority of ward staff and is used for conveyance of patients to appointments, social outings, and occupational therapy (OT) activities. Patients are not charged for using the vehicle. This AFI has been met.	
Area for Improvement No. 3 **Ref:** Quality Standard 5.3.13(f) **Stated:** First time **To be completed by: March 2017**	The Trust must ensure that the ward is subject to a painting schedule and walls requiring repainting should be addressed	**Met**
	Action taken as confirmed during the inspection: The ward décor was in a good state of repair and recent bespoke art work has been completed on communal area walls. This AFI has been met	

5.2 Inspection findings

5.2.1 Patient flow

Clare ward contributes to a weekly bed flow meeting to discuss bed pressures and waiting lists across the BHSCT. Clare ward does not regularly admit patients beyond its maximum number of beds, however, it does consistently occupy beyond the Royal College of Psychiatrists recommendation of 85% occupancy.

Patient flow data provided for inspection was detailed and informative. This is a good mechanism to monitor and inform the weekly bed flow meeting and adhere to the regional bed flow protocol. This information was observed to be detailed, accurate and up to date, and was regularly reviewed.

There were 16 patients admitted to Clare ward at the time of the inspection, three of whom were delayed in their discharge. A lack of suitable community placements was identified as a contributing factor to some of the delays in progressing timely discharge.

Thirteen patients out of the sixteen patients were detained in accordance with the Mental Health Order (Northern Ireland) 1986. Two of the sixteen patients were on a period of leave with the potential for discharge if the leave was successful.

A shortage of admission beds in specialist Learning Disability facilities has resulted in patients with a Learning Disability being admitted to Clare ward from Acute Mental Health wards within BHSCT. Support has been provided by community learning disability teams when required.

5.2.2 Incident management and Adult Safeguarding

The recording of incidents on the Trust's electronic incident management system, known as Datix, between February 2022 and October 2022 was of a good standard.

There was a consistent approach to the grading and management of incidents, and incidents reviewed were noted to have been graded correctly. It was positive to note that staff were using the Trust's grading matrix to grade incidents based on the inherent risk and not the outcome of the incident. Detailed recording of incidents was documented in patient progress notes and there was evidence of multidisciplinary team (MDT) involvement and follow up where appropriate. Datix incident reports evidenced there was consideration given to whether the incident met the ASG threshold for onward referral and appropriate action was taken as necessary.

Mandatory training for incident management and adverse incident reporting was found to be up to date for most staff.

The Adult Safeguarding (ASG) arrangements for the ward were reviewed. ASG is the term used for actions which prevent harm from taking place and protects adults at risk (where harm has occurred or is likely to occur without intervention).

Mandatory training for ASG was up to date for most staff. A safeguarding file was available to staff in the main staff office and there were ASG flow charts and contact details displayed on notice boards, including contact details for ASG personnel out of hours. All staff we spoke with were able to identify the ASG lead and the ASG champion.

Staff displayed good understanding and knowledge of what constituted an ASG incident. A small number of referrals had been made to the ASG Team in the last six months and were responded to in accordance with policy and procedure.

There were no open ASG cases on the day of inspection; the most recent ASG investigation was less than one month earlier and resulted in a protection plan to keep the patient and the staff safe. All staff we spoke with were knowledgeable about the patient's protection plans. The protection plans were only available on the Trusts' electronic record (PARIS) which only Trust staff had access to. It is recommended that protection plans are made available to agency staff, albeit agency staff usage was not high.

The ward has an aligned Designated Adult Protection Officer (DAPO) who attends the ward regularly and is present at the monthly Multi-Disciplinary Team (MDT) governance meetings. The DAPO has completed a Bi-annual ASG analysis document which details actions required. This is displayed in the ward and progress made is discussed at the monthly MDT Governance Meeting.

The ward manager has completed a monthly ASG tracking spreadsheet to track all ASG concerns, APP1 referrals, details of the incident, and the outcomes of any investigations completed. These are discussed at team meetings and shared learning is disseminated to all staff. This was noted as good practice and should be shared across the Trust.

Several other areas of good practice were noted in relation to incident management and ASG. Staff induction directs staff to the ASG file and the notice boards throughout the ward. Shared learning from incidents is displayed in staff only areas and is emailed to all staff. ASG incidents, protection plans, and debrief summaries are discussed during the three times daily handover. Datix incident reports contained referencing to related incidents to provide a pathway of events, and identify themes and trends. RQIA would recommend this good practice is shared across the Trust.

5.2.3 Environment

Patients are accommodated in single occupancy ensuite bedrooms which they have opportunity to personalise. Patients can lock and unlock their bedroom door as they wish. All patients have access to a locker at the front of the ward and have a safe in their bedroom for secure storage of valuables.

The ward décor was in a good state of repair with new, bespoke art work displayed along communal walls. The standard of cleaning throughout the ward was good and there were no malodours. There were adequate private spaces for patients, including TV lounges, OT activity spaces and an enclosed outdoor space.

Two bathrooms are available to patients should they prefer to bathe rather than shower in their own ensuite facility. Laundry facilities and a supervised rehabilitation kitchen are available to all patients on the ward.

There is a visitor's room with an ensuite bathroom; however, there was no door for the bathroom. It was evident through the review of meeting minutes this has been a long standing issue which has not yet been rectified despite escalation from the ward manager. An AFI will be made in relation to the missing door.

A number of potential ligatures and ligature points were observed on the ward, including four profiling beds. It was a concern to observe patients were using the profiling beds without an identified need and there were no specific risk assessments for their use in place. A ligature risk assessment for the ward was available, however, it did not include all potential ligatures or ligature points. These issues were raised with the ward manager during the inspection. Within two days a general risk assessment was received in relation to profiling beds and has been added to the BHSCT Mental Health Risk register; however, individual patient risk assessments have not been completed. An AFI will be made in relation to individual patient profiling bed risk assessments.

All patients have an individualised risk assessment in place, which identifies any additional safety protective measures a patient may require.

A fire risk assessment, containing an action plan, was available and up to date. Personal emergency evacuations plans (PEEPs) had been completed for all current patients.
It is recommended the PEEPS section of the folder is updated as former patient assessments remain in situ.

5.2.4 Restrictive Practices

The management of restrictive practices in the ward was reviewed. Restrictive practices in use included locked doors to manage egress from the ward; levels of patient observations; the use of Pro Re Nata (PRN) medication; and physical interventions. These restrictions had been risk assessed and were proportionate to the level of risk and in line with Royal College of Psychiatrists standards and Royal College of Nursing, Three Steps to Positive Practice, 2017.

The ward operates as a high dependency rehabilitation unit with locked doors meaning patients are reliant on staff for entry and egress. Staff demonstrated good awareness of restrictive practices. It was evident, through documentation, that leadership in the ward, with MDT support, promoted a least restrictive approach to care.

Voluntary patients are made aware, at the point of entry to the ward, that it is a locked environment and are provided with information pertaining to their rights regarding this. Detained patients are provided with information about their rights, including details and contact information for the Mental Health Review Tribunal.

Care records, including patient care plans, demonstrated consideration for patients' rights in relation to restrictive practices. There was evidence of MDT best interests decision making for patients where required.

The use of PRN medication was minimal with evidence that alternative options, such as de-escalation and talking therapies, were considered prior to the administration of medication. Where PRN medication was required, only prescribed first line medication had been used. There was one recorded use of rapid tranquilisation; it was positive to note a Datix had been completed for this and it was recorded as discussed in the weekly MDT meeting minutes.

There were no patients on prescribed enhanced observations at the time of the inspection as a result of concerns about harm to themselves or others. Any enhanced observations observed were as a result of ASG protection plan arrangements.

5.2.5 Patient experience

Patient experience was assessed by directly observing patients experience on the ward and by speaking to patients, ward staff, and patients' relatives.

Patients were observed to be treated with kindness and respect by staff who delivered care in a compassionate manner. Staff responded to patients in a timely manner and demonstrated good knowledge of individual patient needs. Patients were also observed to interact with staff positively.

The ward is a therapeutic environment which was quiet and peaceful at the time of the inspection. Patients appeared comfortable and moved about the ward freely and engaged with staff as they wished.
Quiet spaces are available and observed to be used throughout the day by a number of patients. Patients availed of a range of activities offered to them, amongst them were art work, walks, a men's lunch club, and a visit from a therapy dog.

All patients have a lockable safe in which to store personal items / valuables. This facility was introduced in response to recommendations from an SAI.

Patient advocacy services were signposted around the ward, including contact details of advocates that visit the ward weekly. Information on patients Human Rights and right of appeal re Mental Health Order was displayed on notice boards on the ward.

5.2.6 Care and treatment

Care and treatment for patients was assessed through the observation of patient care, discussions with patients, and their relatives, discussion with ward staff and review of patients care documentation.

There were 16 patients on Clare ward on the day of inspection, the majority of whom were in receipt of care and treatment that specifically met the rehabilitative needs of the patients. Patients are admitted from acute mental health environments, either on a voluntary basis or detained in accordance with the Mental Health (Northern Ireland) Order 1986 (MHO). It is recommended that all patients' legal status is recorded within their records.

It was positive to note that all patients had a named Nurse, an Associate Nurse, and an assigned Health Care Assistant, the details of which were displayed in the staff office, along with the Promoting Quality Care review schedule. Patients we spoke to could identify their named Nurse. It is recommended that patients can access this information within their bedrooms.

Patients are seen by medical staff and have a mental health assessment within 24 hours of admission. Physical health assessments are recorded in the patients documentation and there is evidence of follow up with medical staff where required. Recording and completion of assessments is good and there was evidence of review. Care plans were personalised and detailed with evidence of patient involvement and MDT input.

Weekly and monthly MDT patient review meetings are held with good representation from all relevant MDT agencies.

Patient clinical observations were monitored weekly unless circumstances dictate differently and the results were shared with medical staff at the weekly MDT meeting. There was evidence of MDT input in patient care.

Pharmacy support was provided from another BHSCT site and can be requested by phone.

5.2.7 Staffing

The staffing arrangements on Clare ward were reviewed through the analysis of staffing rotas, discussions with staff, observation of staff on shift and review of the staffing model. Staffing levels on the ward have been determined using the Telford model, which is a tool to assist staff in ensuring appropriate staffing levels based on patients' acuity.

The ward operates within an MDT model of care with a number of allied healthcare professionals (AHP) contributing to the MDT. The ward has a designated Consultant Psychiatrist, two Occupational Therapy (OT) staff, an aligned Social Worker (SW), and input from Psychology staff. Additional AHP can be sourced through a referral process as required.

Staffing levels were being achieved in line with the Telford model. The ward does not frequently require the use of agency staff. The ward manager, alongside staff and bank staff, provide cover when necessary, resulting in minimal usage of agency staff. When a second nurse at night cannot be secured additional health care assistants are on shift. It is positive to note that staff had escalated through Datix when only one nurse registrant was on night shift. Staff vacancies for the ward are low despite a recognised regional shortage of staff.

Staff training records identified deficits in a number of areas of mandatory training which require immediate attention. These areas were shared with the ward manager post inspection. It is positive to note that the majority of staff had completed training for ASG (at an appropriate level for their grade), incident management, and Adverse Incident Reporting. A recent change in the recording of staff training has created difficulty in the oversight of compliance levels of staff attendance. The Trust should ensure that a robust system to record staff training and oversee compliance is in place and available to ward managers. An AFI will be made in relation to staff training and oversight of same.

Staff reported positive morale and described strong leadership and support at ward level. They reported good team work and all staff stated they enjoyed delivering care and support to the patients on the ward.

5.2.8 Patient engagement

Patients we spoke with indicated they are happy with the care they receive and identified a number of staff they could approach if they had a problem. Patients value the respect they are shown by staff and are keen to acknowledge the care and support they receive.

5.2.9 Staff engagement

All staff spoke positively about the ward and the staff team working there. They stated they felt supported by the ward manager and members of the SMT. They reflected on the recent decoration of the ward and how it impacted positively on the patients.

It is positive to note staff did not raise an issue with staffing numbers but alternatively spoke about providing cover and support at times of staffing shortage in order to ensure patients care was not compromised.

5.2.10 Relatives / Next of Kin (NOK) engagement

All relatives we spoke with expressed gratitude and thanks for the care and treatment their loved one had received and stated they had regular communication with the ward manager and the staff. They made the connection between patient progress and recovery to the standard of care delivered by the staff and the support both they and the patients received. Staff were described by relatives as very caring, understanding, knowledgeable about the patients, and brilliant.

Relatives also spoke very highly of the medical staff and stated they had regular contact with the Consultant Psychiatrist.

5.2.11 Governance and Leadership

Governance arrangements were assessed through a review of meeting minutes, discussions with senior staff and observations of care delivery.

The Trust organisational structure is displayed in the staff office alongside contact numbers for all levels of management across the site, including out of hours contacts.

Good leadership and management arrangements at ward level are conducive to an environment that strives to deliver safe and effective care for patients. Staff meetings are held monthly, an agenda, minutes, and action plans for matters arising were available. Staff are encouraged to learn and develop as a team with support from their colleagues and ward manager.

There was evidence of good managerial oversight of the ward. Audits are completed at ward level to include; daily cleaning, weekend cleaning, mattress cleaning & changing, cleaning of medical equipment, and care records amongst others. Action plans for audit outcomes were completed and available.

The ward has a three times daily handover document which includes a wide range of information pertaining to each patient, for example, patient status, arrangements relating to leave, best interests, risks or safeguarding issues and any other significant information. This document is updated daily and kept on the ward for seven days to ensure effective communication between staff regarding each patient's specific needs.

There is monthly monitoring of complaints and compliments by the ward manager at ward level. The last complaint was in January 2022 and there was evidence to support it was appropriately managed.

Patient meetings are held monthly minutes reviewed indicate patient participation, discussion, and actions taken forward. A 'you said we did' notice board is displayed at the entrance to the Ward, to highlight patient contribution, how patient views are valued, and the action taken by the ward as a result of this engagement.

5.2.12 Additional Finding – Model of Care

The Trust confirmed it is providing high dependency rehabilitation, with admissions coming from within the Trust area and the commissioned bed capacity was 16 inpatients.

There was evidence that patients experienced improved outcomes with improved patient flow and discharge arrangements.

RQIA is aware that a dedicated rehabilitation service, based on the recovery model, is the intended future strategic and policy direction and the development of this approach is a clearly defined action in The Mental Health Strategy 2021-2031, for Northern Ireland.

The Trust should confirm that the high dependency rehabilitation service, as currently provided in Clare ward aligns with extant policy. This will ensure commissioning arrangements are agreed with the Strategic Planning and Performance Group and policy leads at the Department of Health and that appropriate performance reporting and funding is in place.

This removes any ambiguity about the relevant best practice standards to apply to the service.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006).

	Regulations	Standards
Total number of Areas for Improvement	N/A	3

The total number of areas for improvement includes three that have been stated for the first time.

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

Quality Improvement Plan

Action required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006).

Area for improvement 1 **Ref:** Standard 6.1 **Criteria:** 6.3.2(a) **Stated:** First **To be completed by:** 31 January 2023	The Belfast health and Social Care Trust must expedite estates work to address the missing bathroom door in the visitor's room. Ref: 5.2.3
	Response by registered person detailing the actions taken: A meeting took place on the 07/02/2023 with the Belfast Health and Social Care Trust (BHSCT), Estates Department and Clare Ward, Senior Management Team to discuss the work requiring completion in Clare Ward including the replacement of the bathroom door in the visitor's room. The bathroom door will be replaced in approximately 8-12 weeks time.
Area for improvement 2 **Ref:** Standard 5.1 **Criteria:**5.3.1 (f) **Stated:** First **To be completed by:** 31 December 2022	The Belfast health and Social Care Trust must ensure specific individual patient risk assessments are completed for patients using profiling beds Ref: 5.2.3
	Response by registered person detailing the actions taken: Each patient using a profiling bed has now been individually risk assessed and included in the patients care plans. The care plans are now audited on a monthly basis to ensure profiling beds risk assessments along with all other documents are up to date.

Area for improvement 3 **Ref:** Standard 4.1 **Criteria:** 4.3 (j) **Stated:** First **To be completed by:** 31 March 2023	The Belfast health and Social Care Trust must ensure that all staff have completed all mandatory training appropriate to their roles and responsibilities. The Trust should also ensure that a robust system to record staff training and oversee compliance is in place and available to ward managers. Ref: 5.2.7
	Response by registered person detailing the actions taken: Staff training records have been transferred to the BHSCT Training Matrix. The Matrix uses a time scale colour alert system to notify managers when training is due to be renewed or updated. This will be updated as staff complete training and will be monitored monthly. The matrix is easily accessed in the shared folder and training due to be renewed is visible at a glance. Staff training has also been added to the agenda at the Development & Quality Improvement meeting.

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

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