The Regulation and Quality Improvement Authority

Unannounced Follow up Inspection Report
18 - 19 September 2017

Clare Ward

Knockbracken Health Care Park
Saintfield Road
Belfast
BT8 8HB

Tel No: 02890638448

Inspector: Alan Guthrie

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

Clare ward is a 20 bedded mixed gender ward located in Knockbracken Health Care Park. The purpose of the ward is to provide ongoing care and treatment to patients with long-term complex mental illnesses.

The multidisciplinary team (MDT) consists of nursing staff, a consultant psychiatrist, a general practitioner, an occupational therapist (OT) and an occupational therapy technician, a social worker and a consultant clinical psychologist.

On the days of the inspection there were 16 patients admitted to the ward. Thirteen patients were detained in accordance to the Mental Health (NI) Order 1986.

3.0 Service details

Responsible person: Martin Dillon	**Ward Manager:** Karen McGovern
Category of care: Rehabilitation and Recovery - low secure ward.	**Number of beds:** 20
Person in charge at the time of inspection: Karen McGovern	

4.0 Inspection summary

An unannounced follow-up inspection took place over two days on 18 - 19 September 2017.

The inspection methodology was to review 13 areas for improvement identified from the previous unannounced inspection completed on 7 – 9 February 2017. On the days of the inspection the inspector evidenced patients as being settled and relaxed in the ward's surroundings. Staff who met with the inspector stated that the ward was patient centred and care and treatment interventions were appropriate and effective. Inspection findings evidenced of the 13 areas for improvement rated by the inspector 11 had been met, 1 had not been met and 1 was removed as it was no longer applicable.

Inspectors noted that the ward had made positive progress in addressing all the areas for improvement identified as a result of the previous inspection. The ward's ligature, environment and fire risk assessments had been updated. Patient's evacuation plans had been updated and daily fire checks were being completed on a continuous basis. One area for improvement has been removed. The completion of DATIX incident forms for every occasion when a patient breached the no smoking policy no longer applied. The trust had updated its procedures to support staff when addressing patients smoking behaviour (for those patients who smoke and present with an acute psychiatric illness). This had resulted in the provision of clear guidelines and procedures for staff when supporting patients who smoke. Staff were no longer required to complete an incident report for every occasion on which a patient was observed to be smoking.

One area for improvement was assessed as not met. The inspector evidenced that on one care plan there was no indication that a review of the plan had been completed within the agreed timeline. This area for improvement will be restated for a second time in the provider compliance plan accompanying this report. The inspector has made two further areas for improvement. One relates to the ward's people carrier which was damaged in June 2017. The second relates a painting schedule for the ward. During the inspection certain walls within the ward were noted to be flaking and require repainting.

Patients stated

The inspector met with five patients. Patients were complimentary about their relationships with staff. Patients stated that they felt safe and secure on the ward, understood their rights and staff had listened to them and treated them with dignity and respect. Patients reported that they felt the ward was strict. Two patients told the inspector that some of the restrictive practices which they had been subject to had not been explained to them. The inspector reviewed both patients care records and noted that the ward's ethos and use of restrictive practices had been explained to each patient previously. The inspector noted that he ward's MDT continually reviewed the use of restrictive practices for each patient. It is important to note that the ward implemented blanket restrictions on mobile phones and aerosols. This was to ensure that patients were kept safe and that staff could manage risks associated with a number of the patients admitted. The inspector evidenced that patients could access their phone and aerosols as required upon request to staff.

During the two days of the inspection the inspector observed staff to be available throughout the ward. Interactions between patients and staff were evidenced as being respectful, supportive and patient centred. Patients moved freely throughout the ward and could leave the ward upon request to staff and in accordance to their assessed needs. Patients who met with the inspector reported that they had no concerns when requesting support from staff.

Patient comments included:

"The ward's a bit strict".

"I have my own room, shower and television".

"I would like more activities".

"It's good I like it".

"It's alright here".

Relatives stated

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

Staff stated

Inspectors met with nine members of ward staff and the ward advocate.

Staff reported that they felt the multi-disciplinary team (MDT) worked well together and that everyone's views were considered. Staff said that they felt listened to and supported by colleagues and the ward's senior management team. Staff stated that they felt the care and treatment provided to patients on the ward was good. Staff felt the ward was safe and that the care and treatment provided by the MDT was patient centred and effective.

Staff informed the inspector that they had no concerns about their ability to access training and supervision. It was also positive to note that staff felt the team was settled and effective.

Staff comments included:

"There is no regional direction for Clare. The team's vision is very clear we are a regional low secure unit with levels of staff to support secure beds".

"The ward is well staffed and we have very low levels of incidents".

"Although we have a consultant psychiatrist and general practitioner who support patients on the ward we have no other psychiatric medical staff".

"Patients present with a lot of physical health care needs".

"Patients requests are always considered by the MDT".

"The ward has a positive enough atmosphere".

"I feel supported working on the ward".

"I attend a reflective practice group for staff. I find it helpful".

"The ward needs a lick of paint".

"Staff are proactive".

"There is very limited accommodation for patients outside the hospital".

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	3

The total number of areas for improvement comprise of one area for improvement being restated for a second. Two new areas for improvement were identified as a result of this inspection.

These are detailed in the Provider Compliance Plan (PCP).

Areas for improvement and details of the PCP 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
- Patient discharge/transfer arrangements
- Minutes of staff meetings
- Records in relation to incidents and accidents
- Staff supervision and appraisal dates
- Staff training
- Staff duty rotas
- Complaints and compliments
- 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 Clare ward was an unannounced inspection. The completed Provider Compliance Plan (PCP) was returned and approved by the responsible inspector. During this inspection the inspector reviewed the areas for improvement made at the previous inspection and an assessment of compliance was recorded as met and not met. This PCP was validated by the inspector during this inspection.

Follow-up on recommendations made following the unannounced inspection on 7 – 9 February 2017

Areas for Improvement		Validation of Compliance
Priority 1		
Number/Area 1 **Ref**: 5.3.1(f) **Stated:** First Time	The ligature risk assessment was not updated to take cognisance of the work undertaken to date.	**Met**
	Action taken as confirmed during the inspection: The inspector reviewed the ward's ligature risk assessment and noted that the work completed was in keeping with the timetable agreed when the ligature assessment review was completed on the 19 October 2016. The inspector was informed that the ligature risk assessment would be reviewed in approximately four weeks' time. The inspector was satisfied that the ward had maintained sufficient records regarding the progress of completed ligature work. This included localised records retained within the ward and records of completion of work retained by estates services.	
Number/Area 2 **Ref**: 5.3.3 **Stated:** Second time	It is recommended that the ward manager ensures that all staff record when a recreational/therapeutic activity is cancelled and the reasons for this. This should be kept under review for any patterns or trends arising.	**Met**
	Action taken as confirmed during the inspection: The inspector reviewed the ward's therapeutic and recreational programmes and spoke with occupational therapy (OT) and nursing staff. The OT and nursing staff provided a continuous programme of activities and these were posted on a notice board located in the ward's main entrance. Although not all patients consented to participate in activities records of patient participation and cancellation of therapeutic/recreational activities was recorded in patient care records. The inspector also evidenced that the ward's activity programme was continually reviewed by the MDT, the occupational therapist and nursing staff. The inspector was concerned to note that the	

	ward's people carrier had not been repaired since being involved in an accident at the beginning of the summer. Whilst staff could borrow a bus from another ward this was not ideal. The inspector asked the ward manager to contact transport services for an update regarding the repair of the people carrier. The ward manager was informed that the vehicle was not repaired. An area for improvement regarding this has been made.	
Number/Area 3 **Ref**: 5.3.1 (f) **Stated:** First Time	A datix form was not completed for every occasion when a patient breached the no smoking policy. **Action taken as confirmed during the inspection**: The trust had updated its smoking policy and guidance for staff since the completion of the previous inspection. Staff were no longer required to complete a datix form for every occasion when a patient breeched the smoking policy. Staff were required to record smoking incidents where there was associated risks for example negative behaviours, aggressions, smoking in bed , potential fire starting etc. Given the updated guidance this area for improvement is no longer applicable and has been removed.	**Removed**
Number/Area 4 **Ref**: 5.3.1 (f) **Stated:** First Time	The fire risk assessment action plan is out of date – dated 9 September 2015. This document needs to reflect updated action points. **Action taken as confirmed during the inspection**: The fire risk assessment had been updated on the 18 October 2016. The assessment was comprehensive and in accordance to the required fire safety review and monitoring regulations and standards.	**Met**
Number/Area 5 **Ref**: 5.3.1 (a) **Stated:** First Time	The Personal Emergency Evacuation Plans (PEEPS) the inspector was shown a system whereby a designated fire officer does review PEEPS however this is recorded on white board but not in patient files. **Action taken as confirmed during the inspection**: The inspector reviewed four patient PEEP assessments. These assessments were retained in patient files and noted to be up to date. Each PEEP was reviewed on a six monthly basis and as required should a patient's needs or physical	**Met**

	presentation change.	
Number/Area 6 **Ref**: 5.3.1 (f) **Stated:** First Time	Daily and weekly fire checks are completed but not on a consistent basis.	**Met**
	Action taken as confirmed during the inspection: The inspector reviewed the ward's daily and weekly fire checks completed during the week prior to the inspection. The inspector evidenced that fire checks had been completed consistently during the previous week.	
Number/Area 7 **Ref**: 5.3.3 (g) **Stated:** First Time	There was an issue in relation to the recording of and storage of baseline occupational assessments on the PARIS system. Baseline assessments were inadvertently being overwritten by updating progress notes.	**Met**
	Action taken as confirmed during the inspection: The inspector reviewed baseline occupational therapy assessments for three patients. These assessments were appropriately recorded on the trust's PARIS electronic patient information system. The assessments were up to date and comprehensive. Previous assessments were also available. The inspector discussed this issue with the ward manager and the ward's new occupational therapist. Both members of staff stated that this concern had been the result of a minor error which had been addressed quickly after the last inspection.	
Number/Area 8 **Ref**: 5.3.3 (b, e and f) **Stated:** First Time	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. **Action taken as confirmed during the inspection**: The inspector evidenced that one patient care plan had not been reviewed in accordance to the required standard. The patients continuing care record did evidence that staff reviewed the patient's progress on a regular basis. However this was not reflected in the patient's care plan. The inspector also noted that the ward was in the process of transferring patient care records onto the trusts T Drive patient information database.	**Not met**
Number/Area 9 **Ref**: 4.2 **Stated:** First Time	Clarity on the future direction, purpose and function of the ward is needed. **Action taken as confirmed during the inspection**: Staff who met with the inspector were clear as to the ward' ethos and purpose. The ward's senior management team demonstrated clear understanding of the ward's future direction and function. The inspector was informed that the ward had a rating of 78% when measured against national standards for a low secure mental health care environment. The challenge for the trust, the senior management team and the ward's MDT has been in relation to securing regional status as a low secure facility. The inspector evidenced no concerns in relation to staff and management understanding the direction, purpose and function of the ward.	**Met**
Number/Area 10 **Ref**: 5.3.3 (f) **Stated:** First Time	Confidentiality – phone calls can still be overheard when made from the nurse's station and staff frequently have to ask patients to remove themselves from the area around the nurses' station while they make phone calls. **Action taken as confirmed during the inspection**: The inspector reviewed the nurse's station layout and observed patient staff interactions throughout the two days of the inspection. The inspector noted no concerns in relation to patients being asked to leave the area of the nursing station. Staff continued to make calls from the station and the inspector observed none of these as being confidential.	**Met**

	The ward's layout and the position of the nursing station made it an area that was inappropriate to make confidential calls from. The inspector was informed that staff had been directed to make confidential calls from the adjoining private room. The inspector was also informed that the ward would be purchasing portable phones that would remain in the nursing station but could be taken to a private room as required. The inspector evidenced that although calls continued to be made from the nursing station when patients were in the surrounding area and could be overheard, none of these calls were of a confidential nature. The inspector was satisfied that there were appropriate measures in place to ensure calls could be made without compromising confidential information and without staff having to ask patients to leave the area.	
Number/Area 11 **Ref**: 5.3.3 (f) **Stated:** First Time	Action points in the Belfast Risk Assessment and Audit Tool 2 (BRAAT 2) were not enacted on the ward**.** **Action taken as confirmed during the inspection**: The inspector reviewed the action points detailed within the most recent BRAAT completed. The inspector noted no concerns regarding action points not being implemented on the ward.	**Met**
Number/Area 12 **Ref**: 5.2.3 (c) **Stated:** First Time	There was no evidence of the use of low-level psychological interventions. **Action taken as confirmed during the inspection**: The ward's therapeutic and activity programme evidenced that patients could attend group work on a regular basis Monday to Friday. Staff had also completed wellness recovery action plan training and this programme was being introduced to patients.	**Met**
Number/Area 13 **Ref**: 5.3.1 (f) **Stated:** First Time	The physical environment of Clare ward did not have any therapeutic enhancement. There was one incomplete attempt at enhancing the environment. The walls were neutral and there were no soft furnishings or pictures to enhance the therapeutic environment. **Action taken as confirmed during the inspection**:	**Met**

	The inspector evidenced the ward's environment to be clean, fresh smelling and well presented. A number of colourful murals had been completed on the walls within the main corridor and new furniture and soft furnishings had been introduced.	

7.0 Other areas examined

The inspector examined no other areas based on findings from this inspection.

8.0 Provider Compliance Plan

The responsible person must ensure that all areas for improvement identified within the PCP 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 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 to Team.MentalHealth@rqia.org.uk for assessment by the inspector by **14 November 2017**.

Provider Compliance Plan	
The responsible person must ensure the following findings are addressed:	
Area for Improvement No. 1 **Ref:** Quality Standard 5.3.1 (a) **Stated:** Second time **To be completed by:**	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.
	Response by responsible person detailing the actions taken: The Deputy Charge Nurse has undertaken an audit of all care plans within Clare Ward. The review and updating of care plans is currently taking place. A meeting with the Lead Nurse Manager aligned to Clare Ward is due to take place shortly regarding the formulation of care plans in the future.
Area for Improvement No. 2 **Ref:** Quality Standard 6.3.2 **Stated:** First time **To be completed by**:	The trust must ensure that patients can access the ward's people carrier car as required.
	Response by responsible person detailing the actions taken: The people carrier available to the ward was out of use at the time of the inspection due to an accident (it has since been repaired and is in circulation once more). During this time patient outings were facilitated by Trust Transport.
Area for Improvement No. 3 **Ref:** Quality Standard 5.3.13(f) **Stated:** Third time **To be completed by**	The Trust must ensure that the ward is subject to a painting schedule and walls requiring repainting should be addressed **Response by responsible person detailing the actions taken:**
	Trust Estates Services are currently awaiting approval of a purchase order for the internal repainting of Clare Ward. Once secured arrangements will be put in place to commence painting.
Name of person (s) completing the PCP	Karen McGovern, Ward Manager, Clare Ward Noel McDonald, Operations Manager Patricia Minnis, Quality and Information Manager

Signature of person (s) completing the PCP	Karen McGovern, Noel McDonald, Patricia Minnis	**Date completed**	30/10/2017
Name of responsible person approving the PCP	Martin Dillon, Chief Executive		
Signature of responsible person approving the PCP	Martin Dillon	**Date approved**	08/11/2017
Name of RQIA inspector assessing response	Alan Guthrie		
Signature of RQIA inspector assessing response	Alan Guithrie	**Date approved**	21 November 2017

Please ensure this document is completed in full and returned to MHLD.DutyRota@RQIA.org.uk from the authorised email address

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