Mental Health and Learning Disability Team
Follow Up Inspection Report

7 September 2016

Neuro Rehabilitation Behavioural Unit
Knockbracken Healthcare Park
Belfast Health and Social Care Trust

Tel No: 028 95 042047

Inspector: Alan Guthrie

1.0 What we look for

2.0 Profile of service

The Neuro Rehabilitation Behavioural Unit (NRU) is an 11 bedded male ward located on the Knockbracken Health Care Park site. The ward provides treatment and rehabilitation to patients who present with an acquired brain injury.

Patients admitted to the ward are supported by a multidisciplinary team that includes nursing staff, health care assistants, a consultant psychiatrist, a psychologist, an occupational therapist and a social worker. A local GP visits the ward twice a week to address any physical health concerns for patients. On the day of the inspection there were ten patients on the ward. Two patients were detained in accordance with the Mental Health (Northern Ireland) Order 1986. One patient was receiving continuous nursing support. The Belfast Trust has informed RQIA that the NRU will be closing in the near future.

3.0 Service details

Responsible person: Martin Dillion	**Position: Deputy** Chief Executive
Person in charge at the time of inspection: Joanne McNally (Ward Manager)	

4.0 How we complete follow up inspections

An unannounced inspection took place on the 7 September 2016. The purpose of this one day inspection was to review the NRU's progress in relation to recommendations made following previous inspections.

Prior to inspection we review a range of information relevant to the service. This included the following records:

- Policies and procedures
- Environmental risk assessment
- Health and Safety assessments
- Fire Safety assessments
- Facility operational policy (to include multi- disciplinary staffing establishment, breakdown of skill mix, gender balance, use of bank/agency staff)
- Training and Development records
- Complaints
- Mental Health Review Tribunal Referrals
- Discharge planning
- Record relating to the use of restrictive practices and deprivation of liberty
- Monitoring of patient experience
- Analysis of risks, accidents, adverse incidents, serious adverse incidents, whistleblowing, safeguarding referrals, staff disciplinary matters, complaints, mortality rates
- Communicating learning to staff and monitor implementation of required changes
- Timely completion of staff supervision and appraisal
- Staffing levels
- Adherence to statutory requirements of mental health legislation
- Monitoring of average length of stay and discharge
- Monitoring of positive results in delivery of care and treatment measured against the expected outcomes of the care pathway
- Monitoring of patient experience and action plans to address areas for improvement.

During the inspection the inspector met with four service users, eight members of staff and two visiting professionals. No service users' visitors/representatives were available to meet with the inspector on the day of the inspection.

The following records were examined during the inspection:

- Four sets of patient care records
- Multi-disciplinary team records
- Policies and procedures
- Staff roster
- Staff supervision timetable
- Clinical room records
- The Trust's PARIS electronic record system
- Complaints
- Incidents, accidents and serious adverse incident records.

What did the inspector do?

- Reviewed the quality improvement plan sent to RQIA by the Trust following the last inspection(s)
- Talked to patients, carers and staff
- Observed staff practice on the days of the inspection
- Looked at different types of documentation

At the end of the inspection the inspector:

- Discussed the inspection findings with staff
- Agreed any improvements that are required

After the inspection the ward staff will:

- Send an improvement plan to RQIA to describe the actions they will take to make any necessary improvements

The findings of the inspection were provided to the service at the conclusion of the inspection.

5.0 Inspection summary

The purpose of this inspection was to assess NRU's progress in relation to the recommendations made following the last unannounced inspection on 7 July 2015. The Trust's progress in implementing a total of five recommendations was evaluated during the inspection. The inspector was pleased to note that all five recommendations had been met and compliance had been achieved. The inspector also met with patients to discuss their views about their care, treatment and experiences. The inspector assessed the NRU's physical environment and evaluated the type and quality of communication, interaction and care practice during direct observations of care practice using a Quality of interaction Schedule (QUIS).

This 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.

The ward's general environment was clean, welcoming and appropriately maintained. Information for patients was available on the ward's notice boards and in NRU's patient information booklet. The ward provided appropriate spaces to allow patients privacy and patients could access the main ward areas and the ward garden as required. The ward's clinical room was appropriately equipped and clean. Equipment within the resuscitation bag was noted to be appropriately maintained.

Throughout the day of the inspection the atmosphere on the ward remained relaxed and calm. Staffing levels were appropriate to meet the needs of patients. Interactions between patients and staff were good and staff remained responsive and supportive to patient requests. Patients presented as being at ease within their surroundings and comfortable in the company of staff. Patients who met with the inspector reported no concerns regarding their ability to access privacy. Patients were complimentary about the ward and their relationships with staff. Patients stated that they could speak with the doctor as required. Patient comments included:

"I love it here";

"The staff are great";

"Don't know what I would do without this place".

The ward provided a range of side rooms for patient use. The dining room was spacious, appropriately furnished and well maintained. The inspector noted that the ward's design and layout incorporated large dorm areas which were in keeping with the ward's previous function as a large admission facility. The inspector was informed that the ward was scheduled to close in the near future. Patients were being supported with transition arrangements which included six of the patients being transferred to a purpose built community based facility. The inspector noted good practice regarding the transition arrangements. Preparation and communication between ward staff and staff who would be supporting patients in their new home was of a high standard.

Staff who met with the inspector demonstrated appropriate knowledge and skill relevant to their role. The ward's multi-disciplinary team (MDT) was described as effective and staff stated they felt the care provided to patients was of a high standard. The inspector reviewed four sets of patient care records. Care plans for each patient were individualised and person centred. Patient care documentation including assessments, risk assessments and care plans were retained in each patient's hard copy file. Continuous care records were recorded on the Trust's PARIS electronic patient information system. Records reviewed by the inspector were noted to be individualised for each patient. The inspector was informed by the ward's senior management team that the Trust continued to progress its PARIS system. Staff stated that it

was envisaged that the majority of patient care records would eventually be retained on the PARIS system. The inspector noted that the transition of patients from the ward and the ward's pending closure had impacted on further development of the ward's electronic records.

Areas requiring improvement were identified. These included:

1. Training Records

Staff who met with the inspector reported no concerns regarding their ability to access training. Nurse training records evidenced that the ward manager had clear oversight of staff mandatory training. However, the inspector evidenced deficits in relation to fire training. This concern is discussed in the ward's provider compliance plan.

2. Staff Personal Alarms

The inspector noted that the ward's alarm system required updating. This concern is discussed in the ward's provider compliance plan.

The findings of this report will provide the NRU with the necessary information to assist them to fulfil their responsibilities, enhance practice and service user experience.

6.0 Inspection outcome

Total number of areas for improvement	2

Findings of the inspection were discussed with the NRU's senior management team as part of the inspection process and can be found in the main body of the report.

Escalation action did not result from the findings of this inspection.

6.1 Review of areas for improvement/recommendations from the most recent inspection dated 07/07/2015

The most recent inspection of NRU was an unannounced primary inspection completed on 7 July 2015. The completed quality improvement plan (QIP) was returned and approved by the inspector who conducted the inspection. The QIP identified five recommendations for improvement. It was good to note that all five recommendations had been implemented:

1. The Trust had completed a review of its PARIS electronic care record system. It was positive to note that progress had been made and continuing care records were retained on PARIS by the majority of professionals represented within the multi-disciplinary team. However not all medical staff were completing electronic updates and progress in transferring other patient care information and records was slow. The inspector was advised that the Trust's future aim and objectives was to retain all patient

care records on electronic format. The inspector was satisfied that the Trust had met the recommendation although progress was limited in this area. Subsequently, the continued transition of patient care records to electronic format has been identified as an area for improvement.

2. The Trust had reviewed the composition of the ward's multi-disciplinary team. It was positive to note that a part time psychologist had been appointed. The inspector met with the psychologist and was satisfied that appropriate psychotherapeutic interventions could be provided as required. It was also positive to note that the Trust had committed appropriate occupational therapy (OT) resources to support patients. Although the ward's previous OT had recently left (June 2016), the inspector was assured by senior staff, including the hospital's lead OT that a recruitment process was in place for the appointment of a new OT in the new future.
3. The Trust had committed appropriate OT resources to support patients on the ward. Although the ward's previous OT had recently left (June 2016), the inspector was assured that a recruitment process was in place and would result in the appointment of a new OT in the new future.
4. The Trust had reviewed the ward's locked areas. The inspector noted that patient's bedroom doors, the door to the garden and doors leading to sitting areas remained open. The ward's main entrance, cleaning storage areas and kitchen remained locked and accessible only to staff. The areas that remained locked presented as a potential risk to patients. The use of locked doors was reflected in the ward's ethos, purpose and patient information booklet. Patients admitted to the ward were reviewed on a regular basis. Individual reviews included assessment of, and justification for, the continued use of restrictive practices including locked doors.
5. The Trust had reviewed the ward's internal environment. On the day of the inspection the ward atmosphere was noted as being calm and relaxed. Patients presented as being at ease in their surroundings and free to move throughout the main ward areas including the ward's garden. Although the ward was large and its environment had originally provided support for a greater number of patients. The inspector evidenced it to be clean, appropriately maintained and fresh smelling. The inspector was informed that the ward was not providing care and treatment for patients suffering from dementia.

7.0 Provider Compliance Plan

Areas for improvement identified during this inspection are detailed in the provider compliance plan. Details of the provider compliance plan were discussed with the ward's management team as part of the inspection process. The timescales commence from the date of inspection.

The responsible person should note that failure to comply with the findings of this inspection may lead to further enforcement/escalation action being taken. It is the responsibility of the responsible person to ensure that all areas identified for improvement within the provider compliance plan are addressed within the specified timescales.

7.1 Areas for improvement

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

7.2 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.

Provider Compliance Plan **Neuro Rehabilitation Behavioural Unit**	
Priority 1	
Area for Improvement	No priority one recommendations were made as a result of this inspection.
Priority 2	
Area for Improvement	No priority two recommendations were made as a result of this inspection.
Priority 3	
Area for Improvement No. 1 **Stated:** First time **To be completed by:** 7 March 2016	The responsible person must ensure that all staff complete their required mandatory training.
	Response by responsible individual detailing the actions taken: As stated in the main body of the report this recommendation related to a deficit in fire training. All staff will have had up to date fire training by 05 December 2016.
Area for Improvement No. 2 **Stated:** First time **To be completed by:** 7 March 2016.	The responsible person must ensure that staff personal alarms are updated to ensure they are effective throughout the ward.
	Response by responsible person detailing the actions taken: The staff personal alarm system has now been updated by Estate Services. This will be kept under review by the Ward Sister.

Name of person completing the provider compliance plan	Joanne McNally		
Signature of person completing the provider compliance plan		**Date completed**	27/10/2016
Name of responsible person approving the provider compliance plan	Martin Dillon		
Signature of responsible person approving the provider compliance plan		**Date approved**	27/10/2016
Name of RQIA inspector assessing response	Alan Guthrie		
Signature of RQIA inspector assessing response		**Date approved**	31/10/2016

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