Unannounced Inspection Report
10 & 11 February 2020

Belfast Health and Social Care Trust
Dementia Inpatient Service
Valencia Ward

Knockbracken Healthcare Park
Saintfield Road
Belfast
BT8 8BH
Tel No: 0289504 4044

Inspectors: Wendy McGregor, Rhona Brennan and Dr Gerry Lynch

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 from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

Valencia is a ten bedded mixed gender ward providing care and treatment to patients with dementia. On the day of the inspection there were eight patients in the ward. Six patients had been admitted to the ward in accordance to the Mental Health (Northern Ireland) Order 1986.

The wards multidisciplinary team included: nursing staff, a consultant psychiatrist, a dementia specialist nurse, a social worker and an occupational therapist. The Belfast Trust's Dementia Outreach Team is located in the same building.

3.0 Service details

Responsible person: Dr Cathy Jack Belfast Health and Social Care Trust BHSCT	**Ward Manager:** Ms Arelene McCrory
Category of care: Dementia	**Number of beds:** 10
Person in charge at the time of inspection: Gillian McGee, Staff Nurse	

4.0 Inspection summary

An unannounced inspection took place on the 10 and 11 February 2020.

This inspection was undertaken by two care inspectors and a psychiatrist.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Mental Health (Northern Ireland) Order 1986 (MH (NI)O 1986) and The Quality Standards for Health and Social Care DHSSPSNI (March 2006).

The inspection was undertaken in response to information received by RQIA from a relative. The concerns related to the staff attitudes, patient care and the standard of care and treatment provided. Additionally RQIA had ongoing concerns regarding morale and leadership from the previous inspection in December 2018. The trust provided assurances regarding this by compiling an action plan to address the concerns and drive changes. The trust shared the action plan prior to the inspection.

The following areas were examined during this inspection:

- patient experience;
- patient risk assessments and care plans;
- management of adult safeguarding;
- management of incidents;
- staff and team leadership .

We reviewed progress against the Quality Improvement Plan (QIP) to assess whether the Belfast Trust had addressed four areas for improvement identified during the previous inspection.

We visited the ward and reviewed the care and treatment provided. Inspectors evidenced the following outcomes:

Areas of good practice:

- The ward had a patient focussed dementia friendly environment;
- Patient observations were completed as prescribed by the MDT;
- Nursing staff were observed as being compassionate;
- Statutory procedures in relation to the Mental Capacity Act (2016) were being implemented.

Inspectors were concerned that:

- The nursing care plans were not completed in accordance with best practice. This area of improvement will be stated for a third time in the quality improvement plan (QIP);
- The lines of accountability for each member of staff were not clear. Staff were not working in line with the Belfast Trust's Working Well Together policy;
- Patients were not appropriately supported to safely manage the risk of choking;
- There was evidence of trend analysis of incidents that had occurred on the ward;
- Safeguarding processes were not implemented in accordance to the required standards; and
- There was failure to comply with the minimum Quality Standards for Health and Social Care (March 2006, DHSSPSNI) in relation to the standards of Leadership.

4.1 Inspection outcome

Total number of areas for improvement	6

Six areas for improvement arose from this inspection. Including, four new areas for improvement, one area for improvement restated for a second time and one area for improvement restated for a third time.

Details of the QIP were discussed with the multidisciplinary team as part of the inspection process. The required timescales for implementation of these improvements commence from the date of this inspection.

This inspection resulted in enforcement action. As a result of the inspection, RQIA were concerned that the quality of care and service within Valencia was below the minimum standards expected in relation to incident management, adult safeguarding processes and leadership within the MDT. The findings were reported to senior management in RQIA, following which a decision was taken to issue a serious concerns letter.

The inspection findings were communicated in a serious concerns letter to the Director of Older Peoples of the Belfast Trust Dr Brian Armstrong. The letters outlined our concerns and have invited the trust to a Serious Concerns meeting on the 20 March 2020.

The enforcement policies and procedures are available on the RQIA website.

https://www.rqia.org.uk/who-we-are/corporate-documents-(1)/rqia-policies-and-procedures/

Enforcement notices for registered establishments and agencies are published on RQIA's website at https://www.rqia.org.uk/inspections/enforcement-activity/current-enforcement-activity with the exception of children's services.

5.0 How we inspect

Prior to inspection a range of information relevant to the service was reviewed, including the following records:

- Previous inspection reports
- Four improvement notices
- Serious Adverse Incident notifications
- Information on concerns
- Information on complaints
- Other relevant intelligence received by RQIA

Each ward was assessed using an inspection framework. The methodology underpinning our inspections include; discussion with patients and relatives, observations of practice; focus groups with staff and review of documentation. Records examined during the inspection include: nursing records, medical records, senior management and governance reports, minutes of meetings, duty rotas and training records.

Areas for improvement identified at the previous inspection were reviewed and an assessment of achievement was recorded as met or not met.

We invited staff to complete an electronic questionnaire during the inspection. No staff questionnaires were received by RQIA.

Findings of this inspection were shared with nursing staff at the conclusion of the inspection. Additional feedback was provided to the nursing and multi- disciplinary team and senior management team on the 25 February 2020.

6.0 The inspection

6.1 Review of areas for improvement from the previous inspection on 6 December 2018

The previous inspection of the Valencia ward was an unannounced inspection undertaken on 6 December 2018.

The completed QIP was returned by the Belfast Trust to RQIA and was subsequently approved by the inspector.

6.2 Review of areas for improvement from the previous inspection on 6 December 2018

Areas for improvement		Validation of compliance
Number 1 **Ref**: Standard 5.3.1 (f) **Stated:** Third time	Nursing staff should ensure that patient care plans are completed in accordance to the required trust standard. This includes evidence of relative /carer involvement in the care planning process.	**Not Met**
	Action taken as confirmed during the inspection: The inspection team evidenced that care plans were not completed in accordance to the required Belfast Trust standard. Care plans did not always reflect the assessed need of the patient. We found that not all care plans evidenced carer involvement.	
Number 2 **Ref**: Standard 4.3 **Stated:** Second time	The Trust must ensure that there are clear lines of accountability for each member of ward staff and the wards MDT. The trust should ensure that all staff work in accordance to the Trusts working well together policy.	**Not Met**
	Action taken as confirmed during the inspection: We found that lines of accountability within the wards MDT and leadership roles were not clear. We were not assured that the measures taken by Belfast Trust to address team dynamics were sufficient to support staff to work in accordance to the working well together policy.	
Number 3 Ref : Standard 5.3.1 (f)	Nursing staff must ensure that patients care plans reflect the needs of patients detained under the Mental Health Order (NI) Order 1986	**Met**
	Action taken as confirmed during the inspection : Care plans detailed that the needs of patients detained in accordance to the MHO were being appropriately addressed. Care plans contained details of the need for the patient's detention for treatment, ongoing assessment and review of the detention process and demonstrated patient and carer involvement.	

Number 4 Ref : Standard 5.3.1 (f)	Nursing staff must ensure that patients care plans record the restrictive practices in place with each patient. The record should include a rationale for the restriction, a time frame and that the use of the restriction is regularly reviewed.	**Met**
:	Restrictive practice care plans were completed when required and included a rationale for use of the restrictive practice and regular review and record of decision making of the continued need for the practice. Two applications for Deprivation of Liberty Safeguards (DOLS) had been completed in accordance to the Mental Capacity (Northern Ireland) Act 2016.	

6.3 Inspection findings

Patient Care Plans

Prior to this inspection we received correspondence from a patient's relative regarding their concerns about the quality of care and treatment provided to patients admitted to the Valencia ward. During the inspection we reviewed four sets of patient care records. We noted that there were three separate sets of care records available for each patient: a care plan file; a MDT file and a physical health monitoring file. We were concerned that the practice of using three sets of different patient care records could result in confusion for staff and/or the risk of patient information being stored in the wrong location. We discussed our concerns with the ward sister. The ward sister outlined that the ward would be embarking on a pilot in relation to care recording. We noted that Clinical (medical) records within the MDT record were up to date, accurate and regularly reviewed.

On the day of the inspection six patients were admitted to the ward in accordance to the MH(NI)O 1986. We were content that the MDT had properly adhered to the required processes Two patients were admitted to the ward on a voluntary basis. Each of the voluntary patients were subject to a deprivation of their liberty as the ward's main entrance door remained locked and the patients were not free to leave. We were pleased to find that statutory procedures in relation to deprivation of liberty safeguards were being progressed in accordance to the Mental Capacity Act (2016).

All patients had comprehensive care plans in place however not all care plans were kept up to date in a timely manner and as a result they did not always reflect the assessed needs of the patient. A care plan for a patient who required a specialised diet was not sufficiently clear. One care plan stated the patient required a level two and three diet (a diet that includes only moist, soft foods) whilst a second plan of care stated the patient required a level 6 diet (foods can be combined with softer foods and purees). This was identified as a potential patient safety risk. This was brought to the attention of the ward sister who agreed to amend and update the care plan. This had been previously identified as area for improvement and will be restated for the second time.

We noted risk assessments completed for each patient. We found that presenting risks for each patient were recorded and updated. However, effective management of the presenting risks for each patient were not reflected in patients' care plans. Subsequently, we were not assured that nursing interventions delivered would be adequately informed by the patient's assessed need. A number of care plans were not completed in accordance with NMC record keeping guidance. This included three care plans that had not been dated or signed.

Evidence was provided of only two care plan audits being undertaken since the previous year. There was not sufficient improvement in relation to the quality of patient care plans since the previous inspection. This area for improvement will be restated for a third time.

The concern raised by the relative, that the quality of care and treatment provided to patients in the Valencia ward was not being delivered to required standards was substantiated.

Patient Experience

Prior to the inspection, a relative had advised RQIA that patients were not appropriately cared for and that prescribed patient observations were not being well managed on the ward. During the inspection there were four patients who were receiving enhanced one to one care from nursing staff. Inspectors noted that for these patients prescribed observations were implemented in accordance to Belfast Trust policy and procedures.

During the inspection we observed nursing staff were compassionate and responded to patient needs in a timely way. Patients appeared at ease in their surroundings and appeared to be enjoying the company of nursing staff. Staff reassured patients and promptly attended to any questions. Staff maintained the privacy of patients at all times – knocked doors before entering rooms and used privacy screens when delivering personal care. Nursing staff told us that patients' and their relatives could access a patient and carer advocate when required.

One of our inspectors met with a relative who was visiting the ward at the time of the inspection. The relative informed that they were satisfied with the care and treatment provided. The relative was complimentary regarding staff attitudes and approach. The relative also reported that staff were approachable and that they knew who to talk to if they had a concern.

The allegation that patient experience and staff attitudes within the Valencia was poor was not substantiated.

Dining Experience

Correspondence received prior to this inspection identified safeguarding concerns in relation to non-adherence to speech and language therapy guidance for one patient. This prompted us to review the dining experience on inspection.

During the inspection we observed the meal time experience. We noted that the dining room was a positive environment for patients however, we were not assured that the meal time arrangements were sufficient to minimise episodes of choking and to appropriately manage a choking incident should one occur. We were concerned that a number of patient dietary plans were not clear and we were unable to confirm that all patents were provided with meals according to their required dietary plan.

Not all staff understood the risks associated with choking for individual patients. Information in relation to choking risks and appropriate interventions should a choking incident occur was not available in the dining room.

An area for improvement in relation to the management of potential choking incidents at mealtimes has been made.

Adult Safeguarding

Prior to the inspection we were informed of safeguarding strategy meetings in relation to a patient admitted to the Valencia ward. As a result we reviewed the safeguarding process and procedures for Valencia ward. We noted three different recording processes were being used for each safeguarding referral completed. An electronic AP1 (safeguarding referral form) form was completed by nursing staff and passed to the ward social worker. The social worker then transferred the AP1 form onto PARIS system. Nursing staff then recorded protection plans on a paper version of a careplan. The referral process was not robust and we were not assured that safeguarding referrals were being appropriately managed. Copies of completed safeguarding referrals were not retained in the ward and as such the ward manager had no oversight regarding the type, quality or quantity of referrals being made. We noted limited opportunities for learning for staff to support proactive approaches and prevent reoccurrence of incidents. We were unable to identify any analysis of the safeguarding information for the patients in Valencia ward, to highlight particular trends or opportunities for improvement. Although the Belfast Trust Adult Safeguarding Gateway service did collate and analyse safeguarding referrals to identify trends this information was not routinely shared with the ward team.

During the inspection we escalated our concerns regarding the adult safeguarding procedures within the Valencia ward to the Belfast Trust senior management team. An area for improvement was identified relating to the management of adult safeguarding incidents and identified these as Serious Concerns in line with RQIAs enforcement procedures.

Incident Management

Processes for the management of incidents and accidents were reviewed which included a review of several reports approved at ward level by the ward manager. Records of incidents were retained on the Belfast Trust's incident database and the DATIX system.

We reviewed incidents that had occurred on the Valencia ward and reported on the DATIX system during the previous four weeks. We found that the Belfast Trust Governance team rated the incidents according to actual outcome rather than the potential severity and likely-hood of reoccurrence. For example in one incident a patient had choked and required nursing care intervention and the use of a suction machine to clear their airway. This incident had occurred as a result of nursing staff not adhering to speech and language guidelines. The incident also resulted in a safeguarding referral and an adult safeguarding strategy meeting. We were concerned that this incident had been graded as insignificant.

We assessed that the governance oversight of incident management within the Valencia ward was insufficiently robust to support ward staff to learn from incidents.

We escalated our concerns regarding the management of incidents within the Valencia ward to the Belfast Trust senior management team. An area for improvement in relation to the management of incidents within the Valencia ward has been made and we have escalated these as serious concerns in line with RQIA's enforcement procedure.

Leadership

Prior to this inspection information provided to RQIA identified concerns regarding poor staff morale and ineffective ward level leadership. During the inspection we found that the membership of the MDT was appropriate to meet the presenting needs of the patients.

RQIA identified concerns following the December 2018 inspection regarding culture and leadership in the ward. We noted that from December 2018 the ward has had five ward managers. We were concerned that the continuing changes in ward leadership were having a detrimental effect on the consistency of care and treatment provided to patients and on staff morale.

Information provided to RQIA prior to this inspection detailed concerns regarding staff attitudes. During the inspection we found that staff morale within the ward appeared low. This was confirmed through our interviews with a range of staff.

Information received from Belfast Trust prior to inspection identified the difficulties with culture and leadership in the ward. Belfast Trust assured us that they had introduced measures to improve the ward's leadership and staff morale. This included the recent appointment of a new ward manager and the introduction of a Service Improvement Group to support ward staff and leadership. We noted the Belfast Trust Nurse Development Leads were involved at ward level to support the ward manager and that values based training had been planned for all staff.

Whilst we welcome the Belfast Trust's action plan for the ward we were concerned to note that the terms of reference for the Service Improvement Group were in draft form and dated July 2017. It was not clear what the current constitution of the group was, when they last met and what accountability arrangements were in place to drive the improvement required.

We noted that nursing staff had no oversight of the action plan. The Consultant Psychiatrist also confirmed the MDT were not involved in the Service Improvement group. We remain concerned that there is not a sufficiently robust plan in place to support the MDT and nursing staff to address leadership and ward culture concerns. An area for improvement regarding leadership has been made and we have escalated our concerns to Serious Concerns.

Further inspection findings

Staffing levels

During the inspection inspectors reviewed staffing levels as a core element to the provision of appropriate care and treatment to patients.

On the morning of the inspection there were five staff on duty – two staff nurses (1 substantive staff and 1 agency) and three Health Care Support Workers (1 substantive staff and 2 agency) Fifty per cent of staff on duty were agency staff. Following a shift change in the afternoon there were four staff on duty. To include two staff nurses and two healthcare support workers. This was below the minimum safe staffing levels. One patient became unwell and had to be accompanied by a staff member to an acute hospital for medical treatment. This reduced staff numbers available to support patients on the ward to three.

We escalated our concerns regarding safe staffing levels to the nurse in charge and the ward's senior management team. The nurse in charge ensured that additional staff were made available for the shift.

The inspection team reviewed duty rotas and the number of staff available per shift during the previous month. We noted that staffing levels on the day of the inspection were comparable to daily staffing levels for the previous month. The duty rosters recorded deficits in staffing levels daily and that approximately fifty per cent of the shifts were completed by agency staff.

Staff told us that they remained concerned regarding the low staffing levels and the high usage of agency staff in the ward and the high level of observations required for patients within the ward.

Total number of areas for improvement	6

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with the nursing and multidisciplinary team as part of the inspection process. The timescales for implementation of these improvements commence from the date of this inspection.

The Trust should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further action. It is the responsibility of the Trust to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

7.1 Areas for improvement

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

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to meet the areas for improvement identified. The Trust should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector by 08 June 2020.

Quality Improvement Plan

The Trust must ensure the following findings are addressed:

Area for improvement No. 1 **Ref**: Standard 5.3.1 (f) **Stated:** Third Time **To be completed by:** 08 June 2020	Nursing staff should ensure that patient care plans are completed in accordance to the required standards. This includes evidence of relative /carer involvement in the care planning process. **Response by the Trust detailing the actions taken:** All nursing documentation within Valencia has been reviewed. The Programs of All-Inclusive Care for the Elderly (PACE) documentation is currently being piloted within Valencia. There is a standardised audit tool for the PACE documentation which will be used by the ward manager during monthly audits of patients notes. Two sets of notes will be audited monthly by the Ward Manager, and will include a review of the quality of the information recorded within the nursing assessment, care plans, risk assessment and daily activity recording. The audit will consider evidence that carers have been involved in the assessment and care planning process. Themes and outcomes of the audit will be used to identify staff's training and development needs and to shape the development of service improvement action plans. On admission carers/ relatives are invited to contribute to the PACE assessment, Personal Profile and the ward Social Worker meets with families of all new patients to complete a social history. All of the above contribute to the MDT assessment and formulation of care needs and ensure input from family and carers. Families are also given the opportunity to attend the MDT meetings for feedback on their relative's assessment and to discuss their relative's health and well-being Carers and family members are updated by telephone if their relative's care needs change and a weekly telephone update is provided to the identified NOK of all patients following the MDT meeting.
Area for improvement No. 2 **Ref**: Standard 4.3 **Stated:** Second Time **To be completed by:** 08 June 2020	The Trust must ensure that there are clear lines of accountability for each member of ward staff and the wards MDT. The trust should ensure that all staff work in accordance to the Trusts working well together policy **Response by the Trust detailing the actions taken:** There are clear lines of accountability from the staff on the ward to the Ward Manager, Assistant Service Manager, Service Manager, Co-Director and Director. The MDT have also been reminded of their operational and professional lines of accountability. All staff

	are encouraged to raise concern via their line management structure. Currently there are no staff issues being addressed through the Conflict, Bullying and Harassment in the Workplace policy and procedure within the ward (formally Working Well Together policy). The policy has been disseminated to all staff to ensure that each team member is clear about their roles and responsibilities within this policy. It is also included as an agenda item for team meetings and discussed at supervision. Staff are provided with training appropriate to their roles and responsibilities within the policy, for example, Conflict Management and Courageous Conversations training. All staff are currently participating in Values based training delivered by the NDL's. This will be followed by planned workshops with the Learning and Development team to complete Valencia MDT objectives and team building sessions with all staff from Valencia. The aim of this development work is to foster a climate of collaborative working and to promote dignity and respect of all staff within the workplace. The management team will continue to work closely with HR and monitor staff turnover, absence rates and staff feedback.
Area for Improvement No 3 **Ref:**Standard 5.31 **Stated:** First **To be completed by:** 08 June 2020	The Belfast Health and Social Care Trust must implement measures to improve the safety of the meal provision. These should include should include speech and language guidance, clear planning in relation to patient staff ratios, and access to trained nursing staff within the dining room during meals.
	Response By the trust detailing the actions taken: evel 2 Eating, Drinking and Swallowing Awareness Training sessions are being delivered by the SLT to all ward staff. The Ward Manager has reviewed and ensured that all staff have attended basic life support training sessions within their mandatory training as per the BHSCT choking policy. n IDDSI and choking folder has been created for the ward and it is kept in the dining room. As part of their induction, staff read this folder and record their signature and the date they did so. All staff must read this information before supporting residents with eating and drinking. he following information is enclosed in it: Two information booklets: How to reduce the risk of choking & Information book to help raise awareness of choking from the following website http://helpstopchoking.hscni.net/pages/advice Copy of 4 choking posters from the help stop choking website

	http://helpstopchoking.hscni.net/pages/posters Appendix 16 from the BHSCT Choking policy; Choking incident flowchart Laminated IDDSI advice sheets for all diet and liquids Copy of the BHSCT choking policy shuttered whiteboard will be erected in the dining area. It displays a copy of SLT eating/drinking/swallowing advice for patients. further small whiteboard (which will be visible for staff beside the kitchen hatch) will display the following laminated posters: First aid for choking Information to help prevent choking Information to help make the room safe High risk choking foods Appendix 16 of the BHSCT choking policy; flowchart for follow up actions and reporting following choking incident he dysphagia care plan is a Trust wide document used by all SLT's in line with the BHSCT choking policy. Following assessment the SLT recommended care plan will be discussed with the nurse in charge and it will be communicated to staff via the nursing handover. One copy of the care plan is kept in the SLT section of the red nursing notes. A second copy is kept in the SLT section of the yellow MDT file. All ward staff have open access to both of these files. n additional two copies of SLT care plan are held in the ward kitchen. The SLT has responsibility for updating these files. One copy is kept on the tea trolley and a duplicate copy is kept on the food trolley to ensure accessibility of documentation to staff. All staff have been advised they must consult these folders prior to assisting any resident with food or fluids. RN supervises the dining area at mealtimes and administers the meals for all patients in line with the SLT care plan. The recommendations within the SLT care plan are reflected in the patients nursing care plan.

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