The Regulation and Quality Improvement Authority

Mental Health and Learning Disability Inpatient Inspection Report
28 February – 2 March 2017

Valencia Ward

Dementia Inpatient Service
Knockbracken Healthcare Park
Saintfield Road
Belfast
BT8 8BH

Tel No: 028 90517500
Inspectors: Cairn Magill and Dr Shelagh-Mary Rea

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

Valencia is a 20 bedded mixed gender ward for patients who require a period of specialised hospital care, due to severely disturbed behaviours, which cannot be assessed, managed and treated effectively in a community setting. On the days of the inspection there were 11 patients on the ward, none of whom were detained in accordance with the Mental Health (Northern Ireland) Order 1986.

The wards multi-disciplinary team included; nursing staff, a consultant psychiatrist; medical staff, dementia specialist link nurse , a consultant clinical psychologist, a social worker, an occupational therapist (OT) and an OT assistant, speech and language therapists, nurses and health care assistants. The ward manager was in charge on the days of inspection. The Dementia Outreach Team is also based in this facility and offers support for patient discharge from the ward back into the community.

3.0 Service Details

Responsible person: Martin Dillon
Ward manager: Donna Matson
Person in charge at the time of inspection: Donna Matson

4.0 Inspection Summary

An unannounced inspection took place over three days from 28 February to 2 March 2017.

This inspection focused on the theme of Person Centred Care. This means that patients are treated as individuals, and the care and treatment provided to them is based around their specific needs and choices.

We assessed if Valencia was delivering, safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in relation to; compassionate care, gathering information on each patient's likes, dislikes, preferences and routine and applying that information to deliver personable care. Care records evidenced, and one relative stated, that the multidisciplinary team members kept relatives informed on patient progress.

There were also good multi-disciplinary working relationships on the ward and good links established with palliative care team and district nurses. Care plans were thorough and comprehensive. Evaluation of treatment and care was reviewed weekly and appropriate and timely changes were made to treatment and care plans. There are well established routines on the ward in terms of scheduling weekly ward rounds, formulation meetings, risk reviews, discharge planning and good preparation and protected time to facilitate these.

There was innovative design of audit tools and information leaflets for patients and relatives on a range of topics related to dementia and caring for someone with dementia.

Areas requiring improvement were identified. These included four areas in relation to documentation and record keeping.

Other areas requiring improvement was in relation to the environment. Some issues identified during the inspection were actioned before the inspection ended and example being the fixing of vertical blinds.

Valencia ward is an old building. It has wide corridors. Towards each end of the corridor there are two, four bedded bays which are open at either side of the corridor. Patients, visitors and staff have to walk through the corridor/bays to get from the centre of the ward to the dining room, lounge and foyer area. There are also four single bedrooms off the main corridor. The ward is showing signs of being tired and worn and is in need of new flooring and repainting. Parts of vinyl floor coverings were taped down with black and yellow hazard tape. This is not in accordance with best practice. Whilst floor coverings were taped down and made safe there is a need for them to be replaced to aid people with dementia in spacial and depth perception as outlined the University of Stirling "*Good practice in the design of homes and living spaces for people with dementia and sight loss.*"

The inspector met with the senior estates officer along with the ward manager. The estates officer advised that a scoping exercise was completed with an architect in order to submit a bid for funding to upgrade Valencia, in relation to work required in bathrooms and to better utilise space and provide a more homely and safe dementia friendly environment. By the end of April 2017 the estates officer is hoping to have the initial designs and projected costs from the architect. If funding is approved by the Trust, the building will have to decant and an alternative accommodation sought before works commences. Works will also consider upgrading the heating system. This meeting also addressed the poor communication on the status of job requests between the ward and estates department.

Patients said

One patient informed the lay assessor that they found it difficult to be around other patients who are not as able as they are. The patient stated that they feel very sad about how the disease affects others.

When asked if there was anything that could be improved one patient stated; *"No – everything is great. I love it here"*

"It's excellent; I would like to stay for good"

"I enjoy sitting in group, I try to join in when I can. I am also able to walk around by myself. In summer it is nice in the garden"

Relatives said

The inspector met with one relative during the inspection. The relative stated;

"I have no complaints about the ward at all."

When the relative was asked if they believed the care and treatment their relative was receiving is beneficial, they replied;

"I was so pleased yesterday when I saw XX"

Staff said
Staff who met with the inspector reported their concerns and anxiety around the forthcoming changes and loss of staff to the nursing team. Two members of the nursing team are leaving; one due to promotion opportunity and one due to health reasons while another three staff will be going off on maternity leave in the summer. During November and December 2016 there were a lot of challenges on the ward covering duty as Valencia ward does not use agency staff so shifts are covered with bank staff. Please note Valencia does use both bank and agency, the service will go also off contract for agency if contracted agencies are unable to cover shifts. Despite this at times shift requests cannot be covered.

Staff stated that a "debrief" process was introduced at the end of each shift to address any incidents that might have occurred during the shift. The purpose of the debriefing process is to identify learning and to provide support to staff. Staff stated that they would prefer if there was more management support during the debriefing exercise. Upon further discussion with staff and the ward manager it was agreed that a way forward might be to reinforce the positive approaches, skills and strengths that staff bring to their role while working patients who present challenging behaviours. Please note the clinical psychologist for the service is available to provide debrief to staff one an indivivual of group basis following incidents, all staff should have been aware of this at time on inspection. However service has reviewed this process since inspection.

"There are good working relationships with the multidisciplinary team. I feel my contribution is valued and it chuffs me how much it is"

"It's a very good team and everybody knows what's going on and everybody is approachable"
"Our assessment, intervention, strategies and advice to patients, family and nursing homes is very effective, this is reflected in no re-admissions"

"Having us ward based and in the same office is really good" – referring to the members of the outreach team.

"Having a psychologist in post means we can work together on strategies and communication"

The findings of this report will provide the service with the necessary information to enhance practice and service user experience.

4.1 Inspection Outcome

Total number of areas for Improvement	6

Findings of the inspection were discussed with senior managers of the trust as part of the inspection process and can be found in the main body of the report.

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.

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

- The operational policy and statement of purpose for the ward.
- Incidents and accidents.
- Safeguarding vulnerable adults policy.
- Complaints Policy.
- Health and safety assessments and associated action plans.
- Information in relation to governance, meetings, organisational management, structure and lines of accountability.
- Details of supervision and appraisal records.
- Policies and procedures.

During the inspection the inspector met with six service users, six staff, one visiting professional and one service users' relative.

A lay assessor Frances McCluskey was present during the inspection and their comments are included within this report.

The following records were examined during the inspection:

- Care documentation in relation to three patients.
- Staff duty rota.
- Training records.
- Care documentation audit tools.
- Discharge Plan proforma.
- Welcome/ information Pack for Patients and relatives.
- Formulation assessments.
- Fire Risk Assessment and Evacuation.

- Job request forms.
- Kardexes belonging to eight patients

During the inspection the inspector observed staff working practices and interactions with patients using a Quality of Interaction Schedule Tool (QUIS).
We reviewed the recommendations/ made at the last inspection. An assessment of compliance was recorded as met/ partially met/ not met.

The preliminary findings of the inspection were discussed at feedback to the service at the conclusion of the inspection.

6.0 The Inspection

6.1 Review of / Recommendations from Last Inspection dated 30 June 2015

Areas for Improvement		Validation of Compliance
Number/Area 1 **Ref:** Standard 5.3.1 (a) **Stated:** First Time	It is recommended that the ward manager ensures that all patients who are assessed as requiring a profiling bed have an individualised risk assessment and management plan in place in accordance with the safety alert raised on 23/12/13 by the Northern Ireland Adverse Incident Centre (NIAC) Estates Facilities Alert /2010/006 associated with profiling beds. This risk assessment should be reviewed regularly to ensure patient safety.	Met
	Action taken as confirmed during the inspection: All patients in Valencia Ward were using a profiling bed. The ward manager informed the inspector that all patients required a profiling bed. General ligature risk assessments were in place for each patient which had a section relating to the use of profiling beds. There was a separate risk assessment in place for the use of bedrails.	
Number/Area 2 **Ref:** Standard 5.3.1 (a) **Stated:** First Time	It is recommended that the Trust ensures that a risk assessment is completed for each patient detailing how environmental ligature risks are going to be managed and reviewed to ensure patient safety.	Met
	Action taken as confirmed during the inspection: The inspector reviewed three files. In all three files reviewed patients had a ligature risk assessment completed.	

Number/Area 3 **Ref:** Standard 5.3.1 (f) **Stated:** Second Time	It is recommended that the trust progress with the issuing of the new ICT Security policy and procedure and review as a matter of urgency the Discipline and Grievance policy and procedure.	Met
	Action taken as confirmed during the inspection: The inspector received a copy of the Belfast Health and Social Care Trust disciplinary Policy updated on August 2015 which stated that it was due for review in August 2017. The ICT Security Policy was operational from May 2009 and was to be updated/ reviewed in May 2010. This is a Trust policy and not a ward policy.	
Number/Area 4 **Ref: Standard 6.3.2 (c)** **Stated: First Time**	It is recommended that the ward manager ensures that information in relation to Human Rights, complaints, advocacy, the Mental Health Order, the Mental Health Review Tribunal and patients' right to access information is in a format suitable to patients' individual needs.	Met
	Action taken as confirmed during the inspection: Inspector noted that there was posters in easy read format pinned to notice boards which explained patient's rights and the Mental Health Review Tribunal. A poster of the Alzheimer's advocate contact details was also displayed. The relative handbook which is issued to carers and family members contained information on complaints, human rights, enhanced observations, and accessing information.	

7.0 Review of Findings

7.1 Is Care Safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them

Areas of Good Practice

There is a good pre-admission screening process and information accompanying the patient.

Two of the three patients care records reviewed had individualised risk assessments in place. The third patient had recently been admitted to the ward. Patient relatives were asked to complete a booklet entitled "All About Me" which informed risk assessments and risk management and care plans.

The range of risk assessments was comprehensive and included Malnutrition Universal Screening Tool (MUST), Infection prevention, skin breakdown, moving and handling, bedrails risk balance tool, risk of falls, ligature risk, deprivation of liberty etc.

Staff had up to date mandatory training in place. The ward manager had a matrix system in place to monitor training needs against mandatory timeframes.

Staff supervision and appraisals were completed in accordance to the required standards.

Staff informed inspectors that the MDT worked well together.

Staff confirmed that they never worked beyond their role and experience.

There was enough staff available during the inspection to meet the needs of the patients in the ward.

All staff knew how to raise concerns around safeguarding, practice issues, or environment.

Environmental, ligature risk and fire risk assessments were all completed and had appropriate action plans devised.

Information on how to make a complaint was contained in the patient/relative handbook.

Medication was appropriate and not excessive.

PRN medication was correctly written on kardexes, with the correct indications for its use and stipulated the maximum doses as per the BNF guidelines.

The use of anti-psychotic medications for some patients was acceptable given the diagnosis and complexity of those patients' conditions.

Areas for Improvement

Most, but not all risk assessments were completed in full nor signed or dated on all occasions.

The recordings of the minutes of the multidisciplinary team meetings did not reflect or capture the breadth of discussion or input from the different members of the multi-disciplinary team members. Abbreviations were used and some entries in fountain pen were illegible.

Job requests which were made to the estates department in December 2016 had not been actioned and there was no feedback provided on the status of the request such as the floor covering. A senior estate officer met with the inspector and wards manager during the inspection to progress job requests and discusses a way forward to improve communication flow.

Number of areas for improvement	3

7.2 Is Care Effective?

The right care, at the right time in the right place with the best outcome

Areas of Good Practice

Care records which were reviewed indicated that patients had a comprehensive assessment of their needs completed. Care records evidenced an assessment of the following patient needs; behaviours, meaningful activity, skin, pain management, communication, mobility, elimination, personal care, oral hygiene, nutrition, hydration, medication, sleeping, deprivation of liberty, infection prevention, moving and handling, bedrails balance tool, risk of falls and ligature risks.

Appropriate care and treatment plans were evidenced in patient care documentation.

Care plans were holistic and co-produced in conjunction with the patient and or their relative. Relatives were asked to complete a booklet entitled "All about Me" to ensure the patient's preferences are known and catered for.

On the morning of the weekly multi-disciplinary team meeting which is scheduled in the afternoon, the ward manager assigns a registered nurse and a health care assistant protected time to review patient's notes from the previous week in preparation for the meeting. (During this inspection two student nurses also accompanied the nurse and HCA) This evidenced good preparation and a focus on gathering relevant information on ABC charts, sleep, appetite, orientation, involvement in activities etc. for the purpose of evaluation.

There was comprehensive discussion in the multi-disciplinary team about the effectiveness of various medications, treatments and interventions. Meetings considered the patient's and family's preference and best interests.

There was a very comprehensive discharge planning process in place. The inspector witnessed discussion on appropriate placement for a patient. The patient's needs were identified first. Discussion occurs between the dementia link nurse and the provider prior to discharge. The provider is asked if they can accommodate the needs of the patient. The link nurse will evaluate if the placement can accommodate the needs of the patient in terms of environment etc.

Family members are also heavily involved in the decision making process. Evidence of good discharge planning is noted in the very low re-admission rates. The specialist dementia link nurse provides ongoing support to patients discharged up to two weeks post discharge.

There are good multi-disciplinary formulation meetings which are led by the consultant clinical psychologist. The formulation meetings facilitate an opportunity for staff to express any issues around patient behaviours and any impact they might have on the staff delivering the care.

Areas for Improvement

Issues arose with documentation proforma. Various members of the multidisciplinary team attempted to squeeze information into boxes on a template that would not accommodate their recordings.

Number of areas for improvement	1

7.3 Is Care Compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support

Areas of Good Practice

Observations throughout the inspection evidenced all staff treated patients with dignity and respect.

Staff knew the personal likes and dislikes, hobbies and interests of each patient. This included important information to help them deliver personal care to the patient in line with their preferences, e.g. some patients may choose to lie on in the mornings while others preferred to get up upon wakening.

The Lay assessor also confirmed that patients agreed that staff responded to their physical and emotional needs in a compassionate manner.

The inspector observed staff making meaningful conversation and using appropriate distraction and diversionary tactics which were personable to the patient, for example staff knew what films certain patients liked and what music they liked etc.

Valencia ward operate an open visiting policy. Relatives are encouraged to visit patients throughout the day.

In the three care records reviewed there was opportunity for relatives to be involved in decisions made about patients care and treatment.

Five out of six patients stated to the lay inspector that they are always involved in all decision about their care and treatment.

Inspector noted in patient files that there is an opportunity for patient's relatives to sign their care plans.

Five out of six patients who met with the lay inspector reported that they were fully involved and provided with appropriate information on their care and treatment.

One file which was reviewed had evidence of a very detailed and thorough best interest meeting in relation to a patient's inability to manage their financial affairs.

The inspector observed that staff were very proactive in explaining to patients what was about to happen an example being the use of a hoist to transfer a patient. Staff explained in a manner

the patient could understand what was happening and used non-verbal prompts and gestures to back up what was being said.

Although the main door to the ward was locked, patients had freedom of movement within the ward. Patients who were disorientated and infringed on other patient's personal space were gently redirected to another part of the ward or another activity.

There were posters on the ward of the Alzheimer's Society Advocate and information on the advocacy service is contained in the patient information/ relative handbook. If the patient has no relative to represent them and there are issues the patient will be referred to the advocate by members of the multidisciplinary team.

Areas for Improvement

No areas for improvement were identified during the inspection.

Number of areas for improvement	0

7.4 Is the Service Well Led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care

Areas of Good Practice

The ward manager, deputy manager and dementia nurse specialist had developed a thorough and very comprehensive care plan and patient record audit tool. Other audits in place include; skin care, hand hygiene and medication administration.

Work is ongoing to develop additional audit tools to review patient experience at meal times, palliative care, activity engagement and tissue viability.

The dementia specialist link nurse produced a copy of a comprehensive discharge plan on a patient. The plan included the finer detail of the patient's preferences. The plan was very prescriptive as to how the patient should be managed. All information is brought to the Multidisciplinary Discharge Strategy meeting and the prescription may reach nine pages. Daily contact is maintained for two weeks reporting to the consultant psychiatrist. It is considered to be a failed discharge if the patient requires readmission. Statistics are kept of readmissions at three months and six months. Very few patients have required readmission.

There is no waiting list for beds.

A patient's capacity for various decisions and human rights issues are usually documented in the Best Interest Meetings. If issues are disputed the Patients Advocate is involved.

Junior doctors cover the Ward and there is reasonable cover at night and at w/ends by the duty rota.

An experienced GP who is full-time on the site manages patients' long term medical conditions very effectively and has daily input to the Ward.

There are good relationships with the Palliative Care Team.

Geriatric medical assistance – advice, outpatient appointments or direct admission to Belfast City Hospital are available.

Whilst there is limited access to Neurology from the ward, patients already known to the Neurology service receive follow-up.

Areas for Improvement

No areas for improvement were identified during the inspection.

Number of areas for improvement	0

8.0 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 at feedback, 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 /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.

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 by 27 April 2017.

Provider Compliance Plan Valencia Ward	
Priority 1	
The responsible person must ensure the following findings are addressed:	
Area for Improvement No. 1 **Ref: Standard 5.3.1 (f)** **Stated:** First time **To be completed by:** 3 April 2017	The recordings of the minutes of the multidisciplinary team meetings did not reflect or capture the breadth of discussion or input from the different members of the multi-disciplinary team members. Abbreviations were used and some entries in fountain pen were illegible.
	Response by responsible person detailing the actions taken: MDT Meeting template has been revised and the new documentation implemented. Medical clinicians recording the MDT discussion have been advised all recordings on this documentation should reflect the full extent of the discussion at the MDT meeting. It should be noted that each MDT member will also make a recording in their professional records of the their discussions, outcomes and any actions arising from the discussion.
Area for Improvement No. 2 **Ref: Standard 5.3.1 (f)** **Stated:** First time **To be completed by:** 3 April 2017	Most, but not all risk assessments were completed in full nor signed or dated on all occasions.
	Response by responsible person detailing the actions taken: The ward sister has reviewed all risk assessments and can confirm that they are fully completed, signed and dated. There is a monthly audit process in place for the audit patient's care plans and risk assessments by the ward manager and Assistant Service Manager. Incomplete documentation identifed during audit will brought to the attention of the Primary Nurse. In addition the ward manger has introduced a weekly process to monitor the quality of completion of risk assessments and will address any descrepency in recording with the patient's Primary Nurse.
Priority 2	
Area for Improvement No. 5 **Ref: Standard 5.3.1 (f)** **Stated:** First time	Issues arose with documentation proforma. Various members of the multi-disciplinary team attempted to squeeze information into boxes on a template that would not accommodate their recordings.
	Response by responsible person detailing the actions taken: All MDT and nursing staff have been advised that information should

To be completed by: 5 June 2017	not be squeezed on to a page outside of the recording format and to ensure that when they run out of recording space, a new page is introduced. The monitoring of compliance with recording within the template format will be monitored as part of the monthly audit process.
Area for Improvement No. 6 **Stated:** First time **To be completed by:** 5 June 2017letio	Job requests which were made to the estates department in December 2016 had not been actioned such as the flooring which needs replaced and there was no feedback provided on the status of the request.
	Response by responsible person detailing the actions taken: The system for recording and monitoring the completion of maintenance tasks reported to the estates department has been revised. A summary template has been developed for the recording of all maintenance issues. The date requested tasks are completed will be recorded on this template. On a weekly basis the outstanding maintenance issues will be followed up with the Estates Department, any maintainence issues breaching the trusts standard time for completion ie urgent and rountine timeframe, will be followed up with the Estates Manager.
Priority 3	
There are no priority 3, areas of improvement.	

Name of person(s) completing the provider compliance plan	DONNA MATSON		
Signature of person(s) completing the provider compliance plan	Donna Matson	**Date completed**	5/5/17
Name of responsible person approving the provider compliance plan	Marie Heaney, Co-Director		
Signature of responsible person approving the provider compliance plan	M Heaney	**Date approved**	05/05/2017
Name of RQIA inspector assessing response	CAIRN MAGILL		
Signature of RQIA inspector assessing response	Cairn Magill	**Date approved**	9/5/2017

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