Mental Health and Learning Disability
Inpatient Inspection Report
2 November 2017

Valencia Ward

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

Tel No: 028 95042044
Inspector: Alan Guthrie

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 providing care and treatment to patients with dementia. On the day of the inspection there were seven patients on the ward. One patient had been temporarily discharged to an acute care general hospital. Five patients had been admitted to the ward in accordance to the Mental Health (Northern Ireland) Order 1986.

The wards multi-disciplinary team (MDT) included; nursing staff, a consultant psychiatrist; a dementia specialist link nurse, a consultant clinical psychologist, a social worker, an occupational therapist (OT) and an OT assistant. The Trust's Dementia Outreach Team is also located within the same building.

3.0 Service Details

Responsible person: Martin Dillon
Ward manager: Donna Matson
Person in charge at the time of inspection: Lyn Noble, Deputy Ward Manager.

4.0 Inspection Summary

An unannounced follow-up inspection took place on the 2 November 2017. The purpose of the inspection methodology was to review four areas for improvement identified from the previous unannounced inspection completed on 28 February – 2 March 2017.

On the day of the inspection the inspector evidenced patients as being settled and relaxed in the ward's surroundings. The ward was clean, fresh smelling, bright and clutter free. Staff who met with the inspector stated that the ward was patient centred and care and treatment interventions were appropriate and effective. However, staff reported that the ward continued to manage challenging staffing levels.

The inspector was informed that the ward's agreed nursing staffing levels were two registered nurses and four health care assistants (HCA's) for the day duty and one registered nurse and two HCA's for the night duty. The availability of appropriately trained and experienced bank and agency nursing staff was limited. Subsequently, the ward manager was not always able to access the number of nursing and HCA staff in accordance to the agreed nursing staff levels for each shift. The inspector was informed that four of the ward's 12 registered nurses were on long term leave. Alongside this four of the ward's 14 HCA's were also unavailable for duty. The inspector was concerned that the frequency of shifts with staff numbers below the agreed levels was placing additional pressure and stress on the core nursing and HCA staff team. Although the inspector had no concerns regarding patient safety on the day of the inspection, he was not assured that the core nursing staff team and HCA's will be able to maintain their current

workload, if day shifts continue to be undertaken without the agreed numbers of nursing and HCA staff.

The inspector discussed the ward's staffing levels with the Deputy Ward Manager and Assistant Services Manager. The inspector was informed that the ward's management team were reviewing nurse and HCA staffing levels on a continuous basis. Recruitment issues had been prioritised by the Trust's Directorate for Older People and staffing numbers within the ward had been placed on the Trust's Corporate Risk Register.

The Deputy Ward Manager explained that there was no restriction on offering bank shifts and the ward's management team continued to pursue proactive strategies to maintain nursing and HCA staffing levels. The trust had prioritised the recruitment and training of more staff and decreased the number of patients being admitted to the ward. The ward's senior management team had reduced the number of patients being cared for from twenty to ten. This decision was taken as a result of an ongoing shortage of staff. It was positive to note that despite the challenges the ward continued to provide three nursing student placements. The inspector was informed that the ward had a sufficient number of nurse mentors to continue to support nursing students.

Given the challenges regarding staffing levels RQIA wrote to the trust's Director of Nursing and User Experience under RQIA escalation policy and associated procedures. Whilst acknowledging the work of ward staff and the trust's plans to address staffing levels on the ward, RQIA requested a copy of the trusts action plan regarding staffing levels within the ward. The trust wrote to RQIA and provided a detailed action plan which was being implemented to address the ward's staffing levels. RQIA noted the trust's plan to be appropriate, robust and detailed. RQIA will continue to monitor the ward's progress and nursing staff levels.

Inspection findings evidenced that of the four areas for improvement identified during the previous inspection, two had been met, one had been partially met and one had not been met.

The inspector noted that the ward had made positive progress in addressing each of the four areas for improvement identified as a result of the previous inspection. Records of minutes from MDT meetings were comprehensive, easy to follow and up to date. Proformas used to record patient progress were appropriately presented and provided staff with sufficient space in which to record patient progress.

One area for improvement was assessed as having been partially met. The ward's Assistant Service Manager had arranged quarterly review meetings with the Trust's Estates Services Manager. These meetings supported continued review of the ward's environment and helped to ensure that job requests were appropriately prioritised and monitored. However, the inspector evidenced that the ward's flooring continued to present as a trip hazard in certain locations. Steps had been taken to highlight the risk through the issue of yellow and black warning tape. The Trust had also submitted a capital works bid to refurbish the ward. Despite the action taken by the Trust the inspector was not assured that this would remedy the potential for patients to trip. This area for improvement will be restated for a second time in the provider compliance plan accompanying this report.

One area for improvement was assessed as not met. The inspector evidenced that two of the three patient risk assessments reviewed had not been completed in full. Whilst the assessment of the presenting risks and associated management plan evidenced that each patient was being

appropriately monitored dates, staff signatures and measurements of the degree of risk presenting had not been completed. This area for improvement will be restated for a second time in the provider compliance plan accompanying this report.

The inspector has made one further area for improvement. Care plans reviewed by the inspector were evidenced as being comprehensive, patient centred and individualised. However, the care plan proforma was not being completed consistently by all staff. Whilst each care plan was clearly presented and personalised on the basis of each patient's presenting needs the bottom section of the plans detailed that care plans had not been shared formally with patients' relatives. Continuing care records evidenced that staff kept patients and their relatives informed of each patient's care and progress. This was not reflected on patients care plans where a relative's signature was required. The inspector was informed that the ward's management team had identified this. This oversight had been as a direct result of the ward's staffing issues as registered nursing staff have been required to prioritise the direct care needs of patients.

Patients stated

The inspector met with two patients formally. Both patients were very complimentary about the ward. Each patient stated that their relationships with staff were positive and staff were friendly, helpful and easy to talk to. Patients stated that they felt safe on the ward and that they knew who to talk to if they were unhappy. Patients reported that they could meet with their named nurse and the consultant psychiatrist as required.

The patients stated that they felt well cared for and that staff explained how they were going to care for them. Neither patient reported any concerns regarding their ability to have time off the ward, to see friends and family. One patient commented that they felt the ward could provide more activities. The inspector explored this issue with the patient. The patient explained that activities were available but these were not always to their liking.

During the day 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.

Patient comments included:

"They are nice people here",

"Yes there are activities",

"I can speak to staff when I need to".

Relatives stated

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

Staff stated

Inspectors met with five members of ward staff.

All of the staff who spoke with the inspector stated that the current nursing staffing levels remained challenging. Staff stated that despite the challenges they felt patients remained safe and were well cared for. Staff informed the inspector that the ward's senior management team had taken a number of steps to address the ward's current nursing staff shortages. This included:

- Placing the current nursing staff shortages on the Trusts risk register;
- Limiting the number of patients admitted to the ward to ten;
- Continuing to proactively recruit new nursing and HCA staff;
- Utilising agency nursing staff as required and when available;
- Senior managers maintaining a presence on the ward;
- Support being provided, as required and when available, by the dementia community nursing staff .

Staff reported that they felt the ward's 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 that they were 'pulling together'. Staff stated that they felt the care and treatment provided to patients on the ward was good. Staff informed the inspector that access to mandatory training was being disrupted due to the current staffing situation.

It was positive to note that the ward continued to provide support to three students completing their nurse training. The inspector spoke to one student. The student had commenced their placement within the previous week. The student reported that they were well supported and that the ward staff remained approachable and helpful. The student reported no concerns regarding supervision and mentoring support.

Staff comments included:

"We're very short of nurses and HCA's at the moment",

"The management team are trying to address this",

"There is no problem contacting bank and agency staff there just isn't the required level of trained staff available….staff who know the patients and know how to work with them",

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 two areas for improvement being restated for a second time. One new area for improvement was 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, the Deputy 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 ares for improvement from the last unannounced inspection

The most recent inspection of Valencia 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, partially met and not met. This PCP was validated by the inspector during this inspection.

Follow-up on recommendations made following the unannounced inspection on 28 February – 2 March 2017

Areas for Improvement		Validation of Compliance
Priority 1		
Number/Area 1 **Ref**: 5.3.1(f) **Stated:** First Time	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.	**Met**
	Action taken as confirmed during the inspection: The inspector reviewed three sets of patient care records. MDT minutes from the previous three months were reviewed. Each record contained a summary of the MDT discussion, a record of those present and agreed MDT actions relevant to each profession where required. Each of the MDT records had been signed by a member of the ward's medical staff. All of the MDT records reviewed by the inspector were legible and easy to follow.	
Number/Area 2 **Ref**: 5.3.1 (f) **Stated:** First time	Most, but not all risk assessments were completed in full nor signed or dated on all occasions.	**Not met**
	Action taken as confirmed during the inspection: Each set of care records reviewed by the inspector evidenced that each patient had a risk assessment completed. Identified risk categories including personal care needs, physical health, mobility etc. and had been assessed in terms of each patients presenting risk in accordance to each category. Two of the risk assessments reviewed evidenced that dates, staff signatures and measurements of the degree of presenting risk were missing. This area for improvement will be restated for a second time on the provider compliance plan accompanying this report.	

Number/Area 3 **Ref**: 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.	**Met**
	Action taken as confirmed during the inspection: Each set of care records reviewed by the inspector evidenced that information was presented in a tidy manner that was easy to read and easy to follow. Recording profromas were legible and the inspector noted no concerns regarding staff having to record outside proforma boxes.	
Number/Area 4 **Ref**: **Stated:** First Time	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.	**Partially met**
	Action taken as confirmed during the inspection: The ward's Assistant Service Manager had arranged quarterly review meetings with the Trust's Estates Services Manager. These meetings supported continued review of the ward's environment and helped to ensure that job requests were appropriately prioritised and monitored. The inspector evidenced that the ward's flooring continued to present as a trip hazard in certain locations. Steps had been taken to highlight the risk through the issue of yellow and black warning tape. The inspector was not assured that this would remedy the potential for patients to trip.	

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 via the web portal for assessment by the inspector by **28 December 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 (f) **Stated:** Second time **To be completed by:** 2 December 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: Risk assessments for all current patients have all been reviewed, completed in full and signed. The risk assessment template has been reviewed and updated to improve governance and the revised template will be implemented for all new admissions. There is an audit process in place to monitor completion of the risk assessment and reviewing audit results will be a standard agenda item on the service's governance meeting.
Area for Improvement No. 2 **Ref:** Quality Standard 6.3.2 **Stated:** Second time **To be completed by**: 2 May 2018	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: Replacement flooring has been chosen and estates are costing the work. Estates will commission contractors in early January 2018 to complete a programme for works including ward painting and replacing the flooring. Patients and staff will be required to decant during this renovation. Alternative accommodation is currently being explored by senior management.
Area for Improvement No. 3 **Ref:** Quality Standard 5.3.1(f) **Stated:** First time **To be completed by** 2 December 2017	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.
	Response by responsible person detailing the actions taken: All patient care plans have been reviewed to ensure they fully reflect the individual needs of patients. Care plans have been audited to ensure compliance with trust standard. A process for monthly audit of care plans is in place and the results of which will form a regular agenda item on the service's governance meeting. Next of kin/ carers involvement has been sought and the next of kin have signed care plans in all but three care plans for patients on the ward currently. Where family/carers have not been engaged in developing care plan or have signed this, staff have documented reasons for this in the patient's file records. .

Name of person (s) completing the PCP	Heather McFarlane		
Signature of person (s) completing the PCP		**Date completed**	19.12.17
Name of responsible person approving the PCP	Donna Matson		
Signature of responsible person approving the PCP		**Date approved**	25/12/2017
Name of RQIA inspector assessing response	Alan Guthrie		
Signature of RQIA inspector assessing response		**Date approved**	10 Jan 2018

Please ensure this document is completed in full and returned to RQIA via the web portal.