Unannounced Follow Up Inspection Report
6 December 2018

Valencia Ward

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

Tel No: 028 9504 2044
Inspectors: Audrey McLellan and Kieran Murray

www.rqia.org.uk

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 ten bedded mixed gender ward providing care and treatment to patients with dementia. On the day of the inspection there were four patients admitted to the ward. Two 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: Mr Martin Joseph Dillion Chief Executive (Acting)	**Ward Manager:** Mrs Jane Hegan
Category of care: Dementia	**Number of beds:** Ten
Person in charge at the time of inspection: Mrs Jane Hegan	

4.0 Inspection summary

An unannounced follow-up inspection took place on the 6 December 2018.

This inspection was undertaken in response to concerns received by RQIA within an anonymous letter. The aim of the inspection was to gather evidence and determine if the allegations were substantiated or unsubstantiated. The findings from the inspection are detailed within the report and measured against current legislation, minimum standards and best practice guidance.

The concerns discussed in the letter related to the following allegations:

1. Patients with mobility difficulties were not being supported.

2. Staff morale is low and there is a culture of bullying.

3. The care and treatment provided to patients is below the required standards and is placing patients at risk.

Inspectors also assessed the progress made by the Trust in addressing the findings for improvement raised from the most recent unannounced inspection of the ward completed 2 November 2017. Upon commencement of the inspection, inspectors met with the ward's management team and informed them of the purpose of the inspection and the nature of the allegations that had been received by RQIA.

Inspectors met with five relatives, the Ward Manager, the Deputy Ward Manager, six ward staff, the duty doctor, the Assistant Services Manager and the Divisional Nurse Lead for Dementia. Inspectors also spoke with the Mental Health Services for Older People (MHSOP) service manager.

Specific methods/processes used in this inspection included the following:

- Discussion with staff and managers.

- Discussion with patients and/or their relatives.
- Examination of patient care records.
- Feedback to the ward management team.

Inspectors noted that patients on the ward presented as being at ease in their surroundings and were actively engaging with ward staff. The ward atmosphere remained calm and relaxed throughout the inspection.

The presenting needs of patients on the ward often resulted in the need for staff to undertake continuous one to one observations with patients. Inspectors evidenced that the ward was experiencing nursing staff shortages and this had continued for a number of months. Managers and staff informed the inspectors that bank and agency nursing staff were completing shifts on a regular basis. Inspectors were assured by the ward manager that bank and agency staff had completed up to date training and understood the presenting needs of the patient group.

It was positive to note the ward had met two out of their three areas for improvement identified at the previous inspection completed on 2 November 2017. Inspectors evidenced that the following areas for improvement had been met:

- Patient risk assessments were completed in full, signed and dated.
- The ward's flooring had been replaced.

The area for improvement relating to the completion of patient care plans in partnership with relatives/carers was assessed as being partially met. Inspectors reviewed four care plans and noted that two of the plans did not evidence relative/carer involvement in the care planning process. This area for improvement will be restated for a second time in the quality improvement plan (QIP) accompanying this report.

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	4

The four areas for improvement comprise of:

- one restated for a second time
- three new areas for improvement

These are detailed in the QIP. Areas for improvement and details of the QIP were discussed with senior trust representatives, members of the multi-disciplinary team, the ward manager and deputy ward manager 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.

The following areas were examined during the inspection:

- Assessments and care plans for four patients.
- Datix records.
- Behaviour record charts.
- Daily skin records.
- Personal care records.
- Fluid balance charts.
- Patient nutritional records.
- Team meeting minutes.
- Staff training records.

Inspectors reviewed the areas for improvements made at the previous inspections and an assessment of compliance was recorded as met and partially met.

6.0 The inspection

Inspectors examined the ward's situation in relation to each of the allegations made in the anonymous letter. The allegations and inspectors findings are detailed below.

Allegation 1 - Patients with mobility difficulties were not being supported.

Inspectors reviewed the wards incident reporting procedures. Incident records in relation to slips, trips, falls and collisions were examined. Inspectors noted these to have been completed in accordance to Trust policy and procedures. Each patient's care plan and falls risk assessments were also reviewed. Care plans and risk assessments were comprehensive and had been completed by the multi-disciplinary team (MDT). Inspectors noted that one patient presented with complex care needs and behaviour that challenged. The patient chose to lie on the floor at different times during the day and night. The patient's care records noted that although the patient chose to lie on the floor staff continued to encourage the patient to desist from doing this as the patient was placing themselves at risk. The patient's care plan, risk assessment, falls risk assessment and continuing care records reflected this. The patient's circumstances continued to be reviewed weekly by the MDT and as required by nursing and medical staff.

The inspectors spoke to five relatives about the care and treatment provided to patients admitted to the ward. Relatives were complimentary and expressed no concerns regarding the care and treatment provided to patients. Comments made by relatives included:

"…staff are all brilliant…….they are kind and have patience, we couldn't fault them."

"Staff in here are really good, better care than in the care home…they know how to work with patients and attend to their needs, you will always get a small percent that are not as good as others but I have no concerns about the care in here"

"Staff are fantastic with mum, even the agency staff they are all great, the staff are amazing…. the ward is well managed, it is very friendly and welcoming it's got a nice atmosphere."

Based on the evidence available to inspectors, on the day of the inspection, the allegation that patients with mobility problems were not being supported was not substantiated.

Allegation 2 - Staff morale is low and there is a culture of bullying.

Staff who spoke to inspectors raised concerns regarding the attitude of some staff members towards others. The inspectors were informed by staff that some of their colleagues continually complained about the rota and demanding that it should be changed. Staff also stated that on other occasions a number of health care assistants (HCA's) were not content to carryout enhanced observations with patients who were admitted to general hospital settings from Valencia. Inspectors were advised by the ward manager that a number of agency nursing staff had reported experiences of feeling 'bullied' by some of the team on the ward.

Nursing staff who spoke to inspectors indicated that they felt that the ward's HCA's were 'ruling the roost'. Nursing staff also stated that they felt some senior members of the multidisciplinary team did not consider the opinions of nurses. Nurses informed inspectors that they felt they were not listened to or valued.

All staff who met with inspectors stated that they felt that morale within the ward was low and that staff morale had been an issue since May 2018. During this period the ward was reported as being very busy with a number of patients presenting with complex needs. Reflecting on this period, staff stated that they felt they were not listened to and their concerns regarding patient safety on the ward were not acted upon. Staff stated that the ward's senior management team took action when ten ward staff became unavailable due to sick leave.

The action taken by the ward's senior management team included:

- The continuous use of agency staff who understood the needs of the patient group.
- Implementing a new management structure including the appointment of a new ward manager. (Inspectors were informed that the ward manager would be leaving her post before February 2019).
- The Trust continued to advertise for new nursing staff.

The ward's senior management team informed inspectors that they were aware of the issues within the staff team and that further action had been taken in an attempt to address these

concerns. This included running workshops nurses and HCA's staff to discuss staff morale and ward dynamics and ways to resolve concerns and attempt to move forward.

The inspectors reviewed the agenda for the workshops. The agenda included reference to the concerns discussed by staff with inspectors as outlined above. Action taken by the ward's senior management team to address team dynamics and morale with in the ward included:

- Creation of a new nursing post (band 6). The role of the nurse will be to work within the inpatient and outreach services. It is envisaged that this role will improve communication between the teams and help ensure appropriate admission and discharge planning for patients.
- Supporting HCA's to access Open University nursing courses.
- Increased training and support for the upskilling of staff to include the provision of internal team building sessions facilitated in partnership with the Trust's Human Resources Department.
- Ensuring team Meetings take place on a monthly basis.
- Ensuring that supervision sessions and supervision templates include reflective practice and learning approaches.
- Ensuring that the ward's weekly team meetings agenda includes reflective practice, teamwork, teaching and case presentations.

Inspectors concerns regarding staff morale and allegations of bullying were discussed at feedback with senior trust representatives including: The Service Manager for Mental Health Services for Older People (MHSOP), the Assistant Services Manager, the Ward Manager, the Deputy Ward Manager and the Trust's Divisional Nurse Lead for Dementia services.

Following the feedback session the inspectors were informed by the Service Manager MHSOP that a meeting with the staff team has been arranged for Wednesday 12 December 2018. Inspectors were advised that the purpose of this meeting was to discuss concerns raised during this inspection. Agenda items for the meeting included: staff attitudes/ incidents of bullying and findings from this inspection. Inspectors agreed a timeframe with the Service Manager to provide RQIA with assurances that the action plan described above has been implemented.

Based on the evidence and feedback from the staff team, the allegation that staff morale is low and there is a culture of bullying was not fully substantiated. Information provided to inspectors evidenced that that staff morale had been low. However, it is important to note that the introduction of an action plan by the senior staff team and the appointment of a new ward manager had supported positive changes regarding morale. The allegation that there was a culture of bullying could not be substantiated. Inspectors were assured through the actions of the senior management team that concerns regarding bullying were taken seriously and were being addressed.

Based on inspectors' findings an area for improvement in relation to leadership within the Valencia ward has been made.

Allegation 3 - The care and treatment provided to patients is below the required standards and is placing patients at risk.

Patients, relatives and staff who spoke with inspectors reported no concerns regarding the care and treatment provided to patients admitted to the ward. Four patients were admitted to the

ward on the day of the inspection. Inspectors reviewed the care records for each patient. Care records were noted to be comprehensive, up to date and based on assessed need of the patient. Patient care plans and risk assessments were reviewed regularly and discussed at the ward's weekly MDT meeting. On the day of the inspection, inspectors found no evidence to suggest that the care and treatment provided to patients was below the required standards. However, inspectors did note that two patient care plans did not evidence relative/carer involvement in the care planning process. Inspectors also noted no concerns regarding the management of risk with individual patients or within the ward in general. However, inspectors observed that care plans did not reflect each patient's status in accordance to the Mental Health (NI) Order 1986 and that the use of restrictive practices was not comprehensively documented. Areas for improvement in relation to each of these concerns have been made and can be found in the quality improvement plan (QIP) at the end of this report.

Based on inspectors' findings on the day of the inspection the allegation that the care and treatment provided to patients is below the required standards and is placing patients at risk was partially substantiated. Whilst there was no evidence that patients were being placed at risk, patient care records reviewed by inspectors evidenced that care and treatment in relation to the use of restrictive practices was below the required standard. An area for improvement has been made in relation to this.

6.1 Review of areas for improvement from the last unannounced inspection 1 - 2 November 2017

The most recent inspection of Valencia Ward was an unannounced inspection. The completed QIP was returned and approved by the responsible inspector. This QIP was validated by inspectors during this inspection.

Areas for Improvement from last inspection		Validation of Compliance
Area for improvement 1 **Ref**: Quality standard 5.3.1 (f) **Stated:** Second time	Most, but not all risk assessments were completed in full nor signed or dated on all occasions.	**Met**
	Action taken as confirmed during the inspection: Inspectors reviewed the risk assessments for each patient admitted to the ward. Risk assessments were noted to have been completed in full, were up to date and had been signed and dated.	
Area for improvement 2	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	

Ref: Quality standard 6.3.2 **Stated:** Second time	of the request.	**Met**
	Action taken as confirmed during the inspection: Inspectors evidenced that the ward flooring had been replaced since the last inspection. Inspectors were informed that ward staff maintained good and effective working relationships with the Trust's estates services department.	
Area for improvement 3 **Ref**: Quality standard 5.3.1 (f) **Stated:** First time	Nursing staff must 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.	**Partially met**
	Action taken as confirmed during the inspection: Inspectors reviewed the care plan for each patient. Two of the care plans did not evidence relative/carer involvement in the care planning process.	

7.0 Quality Improvement Plan

Areas for improvement identified during this inspection are detailed in the quality improvement plan (QIP). Details of the QIP were discussed with senior trust representatives, members of the multi-disciplinary team, ward manager, and ward staff as part of the inspection process. The timescales commence from the date of inspection.

The responsible person must ensure that all areas for improvement identified within the QIP 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.

7.1 Actions to be taken by the service

The quality improvement 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 quality improvement plan to RQIA via the web portal for assessment by the inspector by 20 February 2019.

Quality Improvement 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:** Immediate and ongoing	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 individual detailing the actions taken: On admission, family members are supported to complete the "All about me" document. Information within this document is used to develop care plans that focus on the person's preferences and wishes. A new process has been agreed for the completion and review of care plans. This includes: Primary nurses being allocated time on the off duty to complete,review and update documentation. Roles & responsibilities of primary nurse & keyworker being discussed in 1-1 supervision. ASM undertaking monthly care plan audits. Outcome and areas for improvement identified through audit ,will be discussed with primary nurses at 1-1 supervision and an action plan and period for completion will be agreed. When a patient is admitted to the ward the role of the primary nurse/key worker will be discussed with the NOK and the primary nurse will contact the NOK to discuss the patient treatment plan and planned assessments. All care plans will be discussed with NOK either face to face or if the NOK isn't available to visit the ward a hardcopy of the care plans will posted to the NOK and the primary nurse will make a telephone appointment to discuss and agree the content of the care plans. Service standard of three weeks has been established for discussing new care plans with NOK and obtaining required signatures. Following the weekly MDT meeting families will be updated on the outcome of the meeting and changes to treatment plan. each week.
Area for Improvement No. 2 **Ref:** Quality Standard 4.3 **Stated:** First time **To be completed by**: Immediate and ongoing	The ward's senior management team should ensure that there are clear lines of accountability for each member of ward staff and the ward's MDT. The Trust should ensure that all staff work in accordance to the Trust's working well together policy.
	Response by responsible individual detailing the actions taken: A service improvement group has been established with the aim to work and collaborate as a team to enhance patients experience, maximise staff performance and create a harmonious and positive

	working environment. (See Terms of Reference attached) An action plan is being developed to achieve the terms of reference and will be shared when finalised. A workshop will be facilitated to outline roles and responsibilities of all members of the MDT. Agency staff will be included in this workshop. The trust working well together policy has been circulated to the staff team and discussion in 1-1 sessions will focus each month on how staff view this is being implemented within the staff team. A comments box has been purchased to provide staff with an opportunity to anonymously feedback on their experience of working on the ward. As part of the service development work a questionnaire has been developed seeking staff's comments on their experience working on the ward. (See attached questionnaires). A team building exercise/workshop will be explored and will include all members of the MDT.
Area for Improvement No. 3 **Ref:** Quality Standard 5.3.1(f) **Stated:** First time **To be completed by:** Immediate and ongoing	Nursing staff must ensure that patients care plans reflect the needs of patients detained under the Mental Health Order (NI) Order1986.
	Response by responsible individual detailing the actions taken: ASM will arrange training for all trained staff on the development of "Deprivation of Liberty" care plans and mental health order. Awareness sessions will be explored for primary nurse to highlight their role and responsibility when a patient is regraded or has an extension to their detention. Staff will have allocated protected time on the off duty to complete care plans All trained staff will carry out peer review care plan audits.
Area for Improvement No. 4 **Ref:** Quality Standard 5.3.1 (f) **Stated:** First time **To be completed by:** Immediate and ongoing	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 timeframe and that the use of the restriction is regularly reviewed.
	Response by responsible individual detailing the actions taken: ASM will arrange training for staff on restrictive practice. 1-1 observation is reviewed on a weekly bases at MDT meeting and time frames of need agreed, outlining rationale of restriction. Primary nurse will review initial assessments and care plans while

	evaluating care needs each month. Care plan audit will identify any gaps in recording of restrictive practice and this will be addressed through 1:1 supervision.

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

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