Unannounced Follow Up Inspection Report
22 – 23 January 2018

Ward 12
Lagan Valley Hospital
39 Hillsborough Road
Lisburn BT28 1JP

Inspectors: Wendy McGregor and Audrey McLellan

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Assurance, Challenge and Improvement in Health and Social Care

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

Ward 12 is an 18 bedded mental health acute admission ward located on the first floor of a three storey building and based on the Lagan Valley Hospital site, Lisburn. The ward is a mixed gender ward and can accommodate patients from the age of 18 years. On the days of the inspection there were 18 patients on the ward. Six patients were detained in accordance with the Mental Health (Northern Ireland) Order 1986. There was one patient whose discharge was delayed.

The multidisciplinary team consists of nursing staff, occupational therapists (OT's) social workers, medical staff and four consultant psychiatrists. There are two advocacy services available weekly for patients and their families. A peer advocate is also available.

The ward is spacious and provides a mixture of single room and dormitory accommodation. It has a large dining area, a number of side rooms, a sitting room and an enclosed garden.

3.0 Service details

Responsible person: Hugh McCaughey	**Ward Manager:** Allan Black
Category of care: Mental Health assessment and treatment	**Number of beds:** 18
Person in charge at the time of inspection: Allan Black	

4.0 Inspection summary

An unannounced follow-up inspection took place over two days on 22 – 23 January 2018.

The inspection sought to assess progress with findings for improvement raised from the most recent unannounced inspection 21 - 23 June 2016.

Inspectors noted that the ward had made improvements since the last inspection. Seven out of the nine areas for improvement were assessed as met.

- The fire risk assessment was up to date.
- Corporate mandatory fire awareness training for nursing staff was up to date.
- Housekeeping had increased to twice a day.
- The bathrooms were cleaned to a good standard.
- Hospital porter staff had received training on the management of violence and aggression (MAPA) and were available to staff when required.
- The Trust has recruited security staff to be available on site during the night.

- Administration support was consistent and this reflected in the organisation of the patient's records.
- There was clear evidence that staff contact with relatives / carers was good. Relatives / carers were involved with decisions about their family members care and treatment with patient consent.
- Patient forum meetings occurred every week, facilitated by occupational therapy staff and the patient advocate. The minutes of the meeting were shared with nursing staff and any concerns raised by patients were addressed appropriately. There was evidence that nursing staff attended some meetings.

Since the last inspection it was good to note that a peer advocate had been recruited on the ward.

Inspectors observed that care in Ward 12 was patient centred and the environment during the inspection was calm. Inspectors also observed that staff had a good relationship with patients.

One area for improvement was assessed as partially met. The Team Assessment Meeting (TAM) minutes were not always completed in full.
One area for improvement was assessed as not met, as medical staff continued to record patient reviews / progress into the patient paper files and not onto the patient electronic recording system (MAXIMS). Medical staff were the only members of the multidisciplinary team that were not recording onto the MAXIMS. However the medical director confirmed that they would be issuing a directive on the 23 January 2018 to all medical staff to inform them that medical staff must record onto MAXIMS. This area for improvement will be reviewed on the next inspection.

One new area for improvement was made in relation to the emergency alarm system. An emergency alarm system is activated during an incident on the ward that requires an emergency response for example when a patient presents with aggressive / violent behaviours. A recommendation was made to install a new alarm system following a serious adverse incident (SAI) that occurred on the ward 7 September 2017. RQIA are concerned that this new alarm system has not been installed. It is the view of RQIA that there is a risk to patient and staff safety.

Patient's views

Inspectors received feedback from eight patients. Patients were asked to rate the level of satisfaction in relation to safe, effective, compassionate and well led service from very unsatisfied to very satisfied. Patients were generally positive about their care and treatment.

<u>Safe care</u>
Patients indicated they were satisfied to very satisfied that care was safe. Patients stated they felt safe, secure and supported. Patients said they were aware of their rights and knew how to make a complaint.
Patients said:
"My rights were all explained to me"

"Staff explained to me why the door into the ward was locked"

"I feel safe and secure"

Compassionate care
Patients indicated that they were satisfied to very satisfied that care was compassionate. Patients said that staff treat them with dignity and respect. Patients said they felt listened to. Patients said:

"All the staff are fantastic"

Staff always take time to listen. Staff have taken time to talk to me"

"Staff come and chat to me when I am on my own"

"Staff are all easy to talk to"

"We know what time we get our medication, meetings, and when activities that are running"

"I get my medication in the room with the door shut"

Effective care
Patients indicated that they were satisfied to very satisfied that care was effective. Patients said that they were involved in all decisions about their care and treatment and felt that the care and treatment on the ward was helping them to feel better.
Patients said:

"Weekends can be long as there is no OT so I read my books"

"There is OT involvement. We do badminton, yoga in the old building and walks"

"I am always involved in decisions about my care and treatment"

"The OT is going running with me tomorrow"

"There is plenty to do on this ward. The man here is doing the music and there are OT's"

Well led service
Patients indicated they were very satisfied that the ward was well led. Patients were familiar with the routine of the ward, knew who was in charge and felt that staff have the necessary skills and training to carry out their job.
Patients said:

"The ward manager is very good and the two deputies' are great"

Staff views

Inspectors received feedback from six staff. Staff were asked to rate the level of satisfaction in relation to safe, effective, compassionate and well led service from very unsatisfied to very satisfied. Staff feedback was generally positive in relation to patient care and treatment.

Safe care
Staff indicated they were satisfied that care was safe. Staff said they were well supported. Most staff said there was enough staff on the ward to meet the needs of the patients, however

there can be a reduction in staffing levels on certain days. Staff said they had received up to date training in relation to safeguarding vulnerable adults and were aware of their responsibility to report unsafe practices.
Staff said they were concerned about the risks in relation to medical staff not recording into the MAXIMS and some medical staffs' writing was illegible. Staff raised concerns about the emergency alarm system and said it was ineffective. An area for improvement had been made in relation to this.
Staff said:

"The alarm in the air lock is not effective. It is a portable alarm and cannot always be heard." (An air lock, is a double door entrance system).

"I feel the ward is safe and the team is supportive"

"The environment can be challenging. There are risks as the garden area is downstairs and there are risks on stairs"

"Overall we are well staff"

Compassionate care
Staff said they were satisfied to very satisfied that care was compassionate. Staff said they treat patients with dignity and respect and engaged with patients with warmth and consideration. Staff said that care was person centred and they communicate with patients in a way that is easily understood. All staff said there was a culture of reporting any concerning practice and were confident that these matters would be dealt with. Staff said it can still be difficult to get information for patients when transferred from another trust. Staff also raised concerns that not enough details are always received from other trusts in relation to patient risks. For example a patients' history of violence was not recorded on the patients' risk assessment. Inspectors were aware that these issues are raised at the regional bed management group.
Staff said:

"All staff are very good at what they do on this ward. It can't be easy when patients are very unsettled"

"Patients get 1:1 time with staff. Patients are given time to vent and speak to staff if they have concerns"

Effective care
Staff indicated that they were satisfied to very satisfied that care was effective. All staff said that patients have been assessed and are in the right place for their needs to be met. Staff said that patients are kept informed about to changes to their care plans and referrals to other professionals were actioned promptly.
Staff said:

"There is a TAM meeting every week and daily "huddle" meetings. Patients attend and sometimes next of kin attend on occasions".

"Discharge is planned from admission. We see patients getting better from their admission. There is a good MDT and good working relationships. Patients attend their meetings and are always encouraged to speak."

Well led service
Staff indicated that they were satisfied to very satisfied that the service was well led. All staff said there was a culture of staff empowerment and involvement in running the service. Staff said there was a culture of learning and upskilling and continuous improvement. Staff also said managers are approachable.
Staff said:

"There are no problems getting continuous professional development. The managers are very supportive of our training needs."

"Very organised ward, staff are assigned in the morning to organised duties throughout the day."

"Patients who are transferred from another trust can be a big problem, sometimes the only information we received is what was is written on the detention forms, it can be days before we get the information. Regional electronic patient recording systems do not link up."

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 comprises:
- 2 restated for a second time
- 1 new area for improvement

These are detailed in the Quality Improvement Plan (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 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.

The following areas were examined during the inspection:

Care documentation in relation to four patients.

- Ward environment.
- Staff duty rotas.
- Environmental risk assessments.
- Staff mandatory training records.
- Patient forum meetings.
- Medication administration.

We reviewed the areas for improvements made at the previous inspections and an assessment of compliance was recorded as met/partially met and not met.

6.0 The inspection

6.1 Review of areas for improvement from the last unannounced inspection 21 - 23 June 2016

The most recent inspection of Ward 12 was an unannounced inspection. The completed QIP was returned and approved by the responsible inspector. Inspectors reviewed the areas for improvement made at the previous inspections and an assessment of compliance was recorded as met/partially met and not met.

<table>
<tr><th colspan="2">Areas for Improvement</th><th>Validation of Compliance</th></tr>
<tr><td rowspan="2">Number/Area 1

Ref: Standard 5.3.1 (e) & 4.3 (g)

Stated: First Time</td><td>A. Fire risk assessment was out of date.
B. Corporate mandatory fire awareness training for nursing staff was out of date.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:

Inspectors reviewed the fire risk assessment and the training record for fire awareness training for nursing staff.
The fire risk assessment was up to date and the actions required section had been completed which included the date that the action had been achieved.
Fire training records reviewed evidenced that three out 26 had not received up to date training, however an action plan was in place to address this.</td></tr>
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Number/Area 2 **Ref**: Standard 5.3.1 (f) **Stated:** First Time	Amend cleaning schedule of toilets and showers to ensure it meets the needs of the ward and patient population. **Action taken as confirmed during the inspection**: Inspectors reviewed the cleaning schedule. Housekeeping service had increased to twice a day. Inspectors observed the toilets and showers and noted these were clean and there were no malodours evident during the inspection. Patients who spoke to the inspectors did not raise any concerns about the toilets and showers.	**Met**
Number/Area 3 **Ref**: Standard 5.3.1 (e) **Stated:** First Time	There were occasions when Ward 12 staff did not have access to timely additional support staff when they were dealing with serious adverse incidents that occur at night time. **Action taken as confirmed during the inspection**: Inspectors were informed by the Mental Health Hospital Clinical Manager and the ward manager that hospital porter staff have received training on the Management of violence and aggression (MAPA). Hospital porter staff are available 24 hours every day and can be contacted when required. Ward staff can also contact the PSNI when the need arises. The Trust recognised there is a risk to the safety of staff and patients on the ward and have recruited security staff to be available during the night. This risk has been included on the Trust risk register. Staff raised concerns in relation to the emergency alarm system on the ward. Staff said it cannot always be heard. Three additional portable alarms have been attached to the wall at the air lock corridor leading into the ward. This mechanism was put in place following a serious adverse incident which occurred in that space. The portable alarms are not linked to the main emergency alarm system. Staff said there is a risk	**Met**

	that staff may not hear the alarm. Staff also said that that the alarm system on the ward is temperamental and does not always activate. Some patients who are admitted to the ward initially present with significant risks to the safety of staff and other patients. RQIA were informed by the Mental Health Hospitals Clinical Manager and the ward manager that a capital bid for a new alarm system has been made however no confirmation was received at the time of the inspection when the alarm system will be updated. RQIA are concerned that the alarm system has not been updated. A new area for improvement has been made in relation to this.	
Number/Area 4 **Ref**: Standard 5.3.1 (f) **Stated:** First Time	The Team Assessment Meeting (TAM) record documentation was not completed in full. There was nothing recorded to indicate if the patient was specifically invited to attend their meeting and nothing to evidence if they choose not to. TAM records did not identify which professional would action areas discussed. TAM records were not signed or filed appropriately.	**Partially Met**
	Action taken as confirmed during the inspection: Inspectors reviewed the TAM records in relation to four patients for a period of two months. There were four TAM meetings every week on the ward for each of the four consultant psychiatrists. It was noted that the TAM records were not completed in full in all of the records reviewed. All of records did not always indicate if the patient attended the meeting or if the patient chose not to. All of records did not always identify the professional(s) responsible for implementing the actions agreed at the meeting. Not all of the records were signed or dated. However some improvement was noted as the TAM were filed appropriately in the patients hard copy files. This area for improvement has been assessed as partially met as the TAM records were filed appropriately, however further improvement is required to address the areas as stated. This area for improvement will be restated a second time.	

Number/Area 5 **Ref**: Standard 5.3.1 (f) **Stated:** First Time	The administration support on the ward was not adequate as records were not filed contemporaneously. **Action taken as confirmed during the inspection**: Inspectors reviewed the care documentation in relation to three patients; in particular the records filed and stored in the patients paper files. Administration support to the ward seemed adequate as the all records were filed contemporaneously. The paper copy files were tidy and information could be accessed easily.	**Met**
Number/Area 6 **Ref**: Standard 5.3.3 (a) **Stated:** First Time	Relatives and carers who met with inspectors were unsure as to how they could best support their relatives to recover. **Action taken as confirmed during the inspection**: Inspectors reviewed the care documentation in relation to three patients. There was evidence of good family contact and family involvement in relation to care and treatment. Relatives were invited to attend (with patient consent) the multidisciplinary meetings and to attend meetings with the consultant psychiatrist. There was also evidence of good contact between nursing staff and family. This was clearly documented in the MAXIMS record under the carer contact section.	**Met**
Number/Area 7 **Ref**: Standard 6.3.2 (a) **Stated:** First Time	Patients were not given the appropriate privacy when receiving their medication. **Action taken as confirmed during the inspection**: Inspectors observed the area where medication was administered and during the lunch time medication round. A notice had been put up outside the clinical room, advising patients to remain at a distance when staff were administering medication to another patient. A seated area was available for patients to wait. This was also discussed at the weekly patient	**Met**

	forum meetings. None of patients who spoke to inspectors highlighted any concerns in relation to privacy during medication administration.	
Number/Area 8 **Ref**: Standard 6.3.2 (a) **Stated:** First Time	Nursing input to the weekly patient forum was not consistent. **Action taken as confirmed during the inspection**: Inspectors reviewed the minutes of the patient forum meetings. Nursing staff did not attend all the forum meetings. Forum meetings were facilitated by the occupational therapist and patient advocate. Feedback from the forum meetings was shared with nursing staff in a timely effective way. Any recommendations / concerns raised by patients were actioned. None of the patients interviewed stated that they were concerned that nursing staff did not always attend.	**Met**
Number/Area 9 **Ref**: Standard 5.3.1 (a) **Stated:** Second Time	It is recommended that the trust ensures that medical staff update patient progress records on the Trust's MAXIMS system. **Action taken as confirmed during the inspection**: Inspector reviewed records in relation to three patients on MAXIMS. Medical staff did not update patient records on MAXIMS but continue to hand write medical reviews in the patients paper file. On review of the medical reviews inspectors noted that on some occasions the writing was illegible. It is the view of RQIA that this is a risk to patient safety. Nursing staff confirmed that this was also a risk as they did not always receive a verbal update from medical staff. Nursing staff said at times they were not told of the outcome medical review, or any decisions in relation to changes to care and treatment. For example nursing staff were not informed of the decision making process in relation to granting a patient leave off the ward or any changes to the patients' risk assessment.	**Not Met**

	The inspector met with the medical director. The medical director confirmed that they would issue a directive immediately to all medical staff that they were to record patient information and medical reviews on the MAXIMS. The inspector was informed that this would be actioned immediately. As medical staff had continued to record the information in the patient's paper file since the last inspection, this area for improvement will remain as stated for second time. This will enable RQIA to review this area for improvement on the next inspection.	

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.

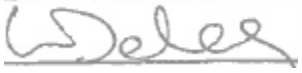
7.1 Actions to be taken by the service

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 via the web portal by **14 March 2018**.

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** 23 April 2018	The Team Assessment Meeting (TAM) record documentation was not completed in full. There was nothing recorded to indicate if the patient was specifically invited to attend their meeting and nothing to evidence if they choose not to. TAM records did not identify which professional would action areas discussed. TAM records were not signed or filed appropriately.
	Response by responsible individual detailing the actions taken: A multi-disciplinary working group with representatives from all acute mental health inpatient wards has been convened to review the TAM documentation. A reviewed TAM document has been developed and will be tested within inpatient wards for three months. It will then be subjected to review and audit by the Audit/Governance Nurse. The audit process will utilise quality improvement methodologies to ensure effectiveness against locally agreed standards
Area for Improvement No. 2 **Ref:** Quality Standard 5.3.1 (a) **Stated:** Second Time **To be completed by**: 23 February 2018	It is recommended that the trust ensures that medical staff updates patient progress records on the Trust's MAXIMS system.
	Response by responsible individual detailing the actions taken: The medical staff within Ward 12 now update all individual patient progress notes on the Trusts Maxims system.
Area for Improvement No. 3 **Ref:** **Stated:** First Time **To be completed by:** 23 April 2018	The emergency alarm system has been reported as ineffective. The alarms in the airlock corridor are not linked to the ward alarm system and the overall alarm system does not always respond when activated.
	Response by responsible individual detailing the actions taken: The emergency alarm within ward 12 has been identified as a specific risk and it has been escalated to the Directorate Risk Register. An identified total costing for the installation a new alarm system's has been identified and is dependent on finance allocation approval from EMT. The tender documents will be issued by estates to tie in with tender returns in April 2018. The alarm system in ward 12 is recognised as the top priority for the installation of a new alarm system.

Name of person (s) completing the QIP	William Delaney		
Signature of person (s) completing the QIP		**Date completed**	16/03/2018
Name of responsible person approving the QIP	Bria Mongan		
Signature of responsible person approving the QIP		**Date approved**	19/03/2018
Name of RQIA inspector assessing response	Wendy McGregor		
Signature of RQIA inspector assessing response	Wendy McGregor	**Date approved**	21 March 2018

Please ensure this document is completed in full and returned to MHLD.DutyRota@RQIA.org.uk from the authorised email address

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