Mental Health and Learning Disability Inpatient Inspection Report
3 – 5 April 2017

Ward J
Female Acute Mental Health
Mater Hospital
45-51 Crumlin Road
Belfast
BT14 6AB

Tel No: 028 95041417

Inspectors: Cairn Magill and Dr Shelagh Mary Rea

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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 J is a 19 bedded acute admission ward for female patients who require assessment and treatment in an inpatient setting. The ward is situated on the first floor of the psychiatric department of the Mater hospital and is staffed by a multi-disciplinary team that includes nursing, medical, social work, and occupational therapy. Clinical psychology and other allied health professional input is provided on a referral basis. The ward has eight single rooms two of which have ensuites and three bay areas which are aligned along one corridor.
During the inspection there were 19 patients, nine of whom were detained in accordance with the Mental Health (Northern Ireland) 1986 Order. Two patients were receiving 24 hour continuous observations and one patient was on intermittent observations.

3.0 Service Details

Responsible person: Martin Dillon
Ward manager: Michael Rooney
Person in charge at the time of inspection: Michael Rooney

4.0 Inspection Summary

An unannounced inspection took place over three days on dates 3 to 5 April 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 Ward J was delivering, safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in relation to the ward having established good working relationships with a range of visiting professionals including the benefit advisor, the carers advocate and peer advocate.

There was appropriate onward referral to specialists for assessment and interventions. The ward had introduced a new tool to monitor the physical wellbeing of patients.

There were weekly patient group meetings for patients to “Have your say” and staff responded to patient requests.

There is a genuine desire to seek continuous improvement and efforts were demonstrated to work towards a number of new initiatives.

Areas requiring improvement were identified. There were a number of areas that required improvement specifically in relation to the environment such as managing ventilation, regulating temperatures and a lack of natural light to rooms in the centre of the building. These concerns are a due to the building and are not in keeping with best practice however the replacement building on the Belfast City Hospital site is under construction. This will be in accordance with best practice for building design of inpatient mental health units.

One patient stated they had nowhere to access to fresh air as the walled garden was small and used by smokers. The lack of alternative outdoor safe space presents a challenge to the trust to accommodate the right to fresh air for non-smokers.

Escorting patients off the ward to the walled garden for a smoke break has a significant resource implication for staff on the ward. Generally, patients who smoke are facilitated to have one cigarette every hour on the half hour. However this time off the ward for staff to accommodate these patients is not captured or recorded and has a direct impact on the completion of duties for the ward. During discussion with the ward manager and deputy ward manager, it was suggested that is recorded as a baseline for capturing staff time required for meeting those patients requirement for a cigarette.

A shared understanding of the multi-disciplinary team roles, responsibilities will enhance the working relationships especially when the ward becomes busy and when and under what circumstances one profession can support another to meet patient needs. This issue was discussed during feedback and will not be noted in the provider compliance plan as it has been addressed at feedback.

Medication was within BNF guidelines and appropriate. Discussion during feedback raised the issue of completing a review of the prescribing of benzodiazepines. Ward staff present during feedback advised that this issue had to be considered in context of the local issue and the known phenomenon of the high usage of benzodiazepines within West Belfast.

Patients said

The inspectors met with six patients during the inspection.

One patient reported that if they only wanted to wash their hair they couldn't as they had to have a full shower. Another patient reported that doors bang too loudly at night time.

"The staff really are very attentive always listen to me. The staff are the best thing about the ward."

"They always try to get patients involved."

"They let my family come up outside and over visiting times"

"The majority of staff 95% of staff that works here has compassion and empathy – building rapport makes all the difference."

"There is a good mix of ages of patients. You can have privacy when you want it or company. Staff on view are generally accessible and approachable."

Four patients stated staff responds compassionately and quickly when they need help and two patients stated staff respond quickly but not always compassionately.

When asked if there was anything that could be improved patients stated they would like;

"More updated décor for the TV room which is just off the main ward- they (staff) are asking patients what colours would they like?"

"Bingo nights with small prizes like shower gel just something to have a fun element because we can't go for a walk or get off the ward. I would love more interactive activities like Pictionary."

“My experience on Ward J has been made easier by staff being happy, friendly and approachable. They have made my stay easier.”

Relatives said

Inspectors met with one relative and one other relative completed a relative questionnaire. The relative who met with the inspector stated that staff were so reassuring and supportive. Both relatives noted in the questionnaire that staff informed them of the patient’s rights and how the ward was run.

“Staff are available, friendly and helpful at all times”

“Staff are great and work with me and XX. This is a difficult time and they are keeping me informed.”

Staff Said

The inspector met with six members of nursing and nursing assistant staff, and the social work manager and occupational therapy service manager and three visiting professionals. Everyone reported excellent working relationships and stated that all ward staff were approachable, welcoming and that multidisciplinary relationships were good.

“I’m a new member of staff. The team are very supportive. Everyone is very good. We work well together. Dr X is fabulous; he is always on the ward. The SHO’s and junior doctors are brilliant, social workers and occupational therapists are very involved as is the benefit advisor”

“It can be very stressful being the nurse in charge as all you have below you is brand new nursing staff and I want to support them and make sure everything is done right and I have to ensure I see my own patients as well as run the ward and do allocations of duties. I am asked very often to be the nurse in charge.”

“The ward is very good. Patients are looked after very well and they are well cared for and seem so happy. ”

“X bought new hair dryers and straighteners. You know it makes the patient’s day when you are doing their hair or make-up, just listening to them. That’s what makes my job worthwhile to see a light on their face.”

“There are some very, very good people working here”

“There is a big issue around smoking.”

“When there are admissions at night time it takes someone off the floor to be with the doctor to complete an admission.”

“I do feel for patients on the ward who can’t get access to fresh air”

When the social worker was off it was difficult because we had to do a lot of linking in with teams in preparation for patients discharge. It’s better now that there is more social work presence on the ward.”

“We have more patients now with eating disorders and we have had no specialised training on eating disorders. We do link in with the community eating disorder team and with psychology on the ward and they are very good for support”

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	14

Findings of the inspection were discussed with the ward manager and other senior members of the Belfast Trust as part of the inspection process and can be found in the main body of the report.

Escalation action did not result from the findings of this 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.

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

- The operational policy.
- Incidents and accidents.
- Safeguarding vulnerable adults.
- Complaints.
- 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 of staff, five of visiting professionals and one of service users' visitors/representatives.

The following records were examined during the inspection:

- Care documentation in relation to three patients.
- Staff rota.
- Training records.
- Fire safety file
- Ward Ligature risk assessment and action plan
- Minutes of Patient's "Have your Say" meetings

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.

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 Areas for Improvement / Recommendations from Last Inspection dated 4 August 2015

Areas for Improvement		Validation of Compliance
Number/Area 1 **Ref**: Standard 5.3.1 **Stated:** First Time	It is recommended that the ward manager ensures that the recommended actions as detailed on the ward's ligature survey report are implemented	**Partially Met**
	Action taken as confirmed during the inspection: Some actions in the ligature risk assessment were completed but others were not completed. Consideration was given to covering pipes in ensuites in side rooms 2 and 3. However as these were ensuites with a shower installed any wooden construction to box in pipes would warp with the water and steam. The low level piping in the large TV room was not boxed in. This recommendation will be restated for the second time.	
Number/Area 2 **Ref**: Standard 5.3.1 **Stated:** Third Time	It is recommended that the ward's bathroom and toilet areas be refurbished. This should include the replacing of burn marked flooring and the replacing of shower curtains.	**Met**
	Action taken as confirmed during the inspection: The two main bathrooms on the ward were fully refurbished and upgraded.	

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

All staff know how to manage a complaint and to escalate concerns around child protection and vulnerable adults.

Patients who were detained in accordance with the Mental Health (Northern Ireland) Order 1986 were informed of their rights.

Medication dosages were within the British National Formulary BNF guidelines.

There is a consultant pharmacist who reconciles mediation on the ward.

Bathrooms, ensuites and side rooms are fitted with cigarette smoke alarms which sound when activated.

All staff wear safety pagers and a system is in place where two staff from the additional two psychiatric wards respond to a call when required.

Patients are aware of how to make a complaint.

The annual 'Walk through Fire drill' was completed.

The assessed safe levels for staff patient ratio have been maintained.

Ward environmental risk assessments were up-to-date and in place.

Areas for Improvement

Staff were not completing and submitting a datix entry on every occasion where patients smoke on the ward or when the cigarette smoke alarms which are fitted in bathrooms and side rooms are activated.

The actions as detailed on the ward's ligature survey report were not implemented. This includes the boxing in of low level piping in the ensuites to side rooms 2 and 3 and the large TV room.

Updated status and any measures taken to progress action points on (a) the ward ligature risk assessment and (b) fire risk assessment action plan were not recorded on the prescribed documents to evidence that action has been taken by the appropriate responsible person/ department.

Patient's comprehensive safety risk assessments were not completed in full, acknowledging patient involvement and consideration of patient's human rights in the assessment. There was no recording of the contribution of the multidisciplinary team members in the assessment.

The review of risk assessments did not evidence who was present at the review and any changes made and the rationale for these changes.

The flooring outside the door to the ward at the top of the stairwell was ripped and needs replacement.

The weekly or monthly checks required (e.g. door closures) did not record the job requests number against comments section to evidence that the appropriate action has been taken.

The temperature recording of the medication fridge was not logged on a consistent daily basis.

Number of areas for improvement	8

7.2 Is Care Effective?

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

Areas of Good Practice

There was evidence of onward referral for specialist assessment when required.

There was a good compliment of disciplines on the multi-disciplinary team.

There was evidence of group and individual activities on offer for patients throughout the day, evenings and weekends.

The need for the use of restrictive practices, including deprivation of liberty, restraint and seclusion is based on individualised assessment of need.

The ward had implemented a physical health monitoring care plan which recorded the weekly, and if required, daily monitoring of clinical observations including blood pressure, weight etc. This was noted by the consultant psychiatrist as beneficial.

The ward is participating in the Prescribing Observatory for Mental Health study into the prescribing of high dose anti-psychotic medication. This is a national bench-marking scheme.

Areas for Improvement

The feedback from the two patients who were trialled using the Regional Mental Health Care Pathway entitled “You in Mind” was positive and the deputy nurse reported that it promoted ownership from the patient and co-production. This was not common practice for all patients.

There was no evidence that care plans were evaluated.

Minutes of the multi-disciplinary team did not reflect the breadth of discussion on patients or the contribution of all disciplines.

A consistent approach is needed for all care documentation, such as an agreement reached when risk assessments, care plans etc. are electronic or written record.

Number of areas for improvement	4

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

Patients have access to peer advocate who visits the ward several times per week.

Patients have access to benefit advisor who visits the ward once per week.

There is a carer's advocate who visits the ward once per week.

Patients have a weekly meeting entitled "Have Your say".

Ward staff respond to patient feedback. This was evident in relation to patients requesting a lighter lunch at midday rather than a full meal.

Two relatives completed the questionnaire and stated that they were happy with how their relatives were treated from admission and the care offered to them.

Patients reported staff always seek permission before completing any aspects of care and treatment.

Patients have the opportunity to have a representative of their choice attend any meeting about their care and treatment.

Five out of six patients reported that all or "almost all" staff listen to them and take their views into account.

Areas for Improvement

There are no areas for improvement.

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

Medical and nursing staff have stated that the mental health pharmacist presence on the ward and contribution to the ward round is a valuable resource.

Medical and nursing staff participated in a Prescribing Observatory for Mental Health POMH a National bench mark accreditation scheme across 59 mental health trusts in the UK. Deputy Ward manager collected data for submission.

There is a willingness by medical staff to be involved in the Royal College of Psychiatrists Quality Improvement Initiative for junior medical staff in prescribing high dose anti-psychotics which is also a national bench marking scheme.

There are good multi-disciplinary working relationships. This extends to the visiting professionals such as the benefit advisor, the peer advocate and carer's advocate, all of whom reported that they are welcomed onto the ward and have established good relationships with ward staff.

There is a monthly clinical governance meeting for the three wards Ward J, Ward K and Ward L. An analysis of incidents and datix's are completed and discussed for learning and informing good practice.

All staff reported that they have had regular supervision and appraisal records evidence this.

A training needs matrix is in place and is colour coded to enable timely appropriate planning to ensure staff are up-to-date on all mandatory training.

There is an opportunity for staff to access a reflective practice session.

There is a psychological therapeutic subgroup in place which looks at solution focused brief therapy interventions and motivational interviewing.

Plans are in place to deliver a two week programme of enhanced psychological therapies in May 2017. Funding was given from the Health and Social Care Board (HSCB) to the Trust to deliver Dialect Behavioural Training, DBT.

The challenge to ensure the ward has appropriate skill mix on every shift has been managed well in light of the loss of eight experienced staff.

Areas for Improvement

Some patients have been admitted with eating disorders and staff stated they had no specific training around the management of eating disorders such as nasal gastric feeding and administrating IV fluids.

There were not enough fire wardens to have one scheduled on every shift.

Number of areas for improvement	2

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 26 May 2017.

Provider Compliance Plan Ward J	
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 May 2017	Staff were not completing and submitting a Datix entry on every occasion where patients smoke on the ward or when the cigarette smoke alarms which are fitted in bathrooms and side rooms are activated.
	Response by responsible person detailing the actions taken: The Ward Manager has sent an email to all staff reminding them of the need to complete an incident report on every occasion where patients smoke on the ward or when the cigarette smoke alarms are activated. This will also be discussed at future staff meetings.
Area for Improvement No. 2 **Ref:** Standard 5.3.1(f) **Stated:** First time **To be completed by:** 3 May 2017	A consistent approach is needed for all care documentation, such as an agreement reached if risk assessments, care plans etc. are electronic or written record.
	The Trust is in the process of moving completely to electronic records however there will be a time period when both paper and electronic systems will be in operation due to the PARIS system not being fully functional. The service is aware of this and has put it on the Mental Health Risk Register. The senior team are currently liaising with IT to develop an action plan for resolution
Area for Improvement No. 3 **Ref:** Standard 5.3.3 (a) **Stated:** First time **To be completed by:** 3 May 2017	The feedback from the two patients who were trialled using the Regional Mental Health Care Pathway entitled “You in Mind” was positive and the deputy nurse reported that it promoted ownership from the patient and co-production. This was not common practice for all patients.
	Response by responsible person detailing the actions taken: As noted above, the use of the Regional Mental Health Care Pathway, entitled, “You in Mind” with two patients was part of a trial. The Regional Mental Health Care Pathway’s documentation has not been finalised as yet, thus it has not been rolled out to all patients. This documentation will be rolled out across the region including Belfast Trust wards once finalised

Area for Improvement No. 4 **Ref:** Standard 5.3.1 **Stated:** Second time **To be completed by:** 3 May 2017	The actions as detailed on the ward's ligature survey report were not implemented. This includes the boxing in of low-level piping in the ensuite to side rooms 2 and 3 and the large TV room.
	Response by responsible person detailing the actions taken: A job request (C709178) has been submitted to Estates Services to address this.
Area for Improvement No. 5 **Ref:** Standard 5.3.1 **Stated:** First time **To be completed by:** 3 May 2017	**Updated status and any measures taken to progress action points on (a) the ward ligature risk assessment and (b) fire risk assessment action plan were not recorded on the prescribed documents to evidence that action has been taken by the appropriate responsible person/ department.** The Ward Manager will amend this documentation to reflect progress action points on both documents.
Area for Improvement No. 6 **Ref:** Standard 5.3.1 (a) **Stated:** First time **To be completed by:** 3 May 2017	Patient's comprehensive safety risk assessments were not completed in full, acknowledging patient involvement and consideration of patient's human rights in the assessment. There was no recording of the contribution of the multidisciplinary team members in the assessment.
	In the absence of a mechanism for patients to sign electronic records, a note that the patient was involved in the completion of the risk assessment will be entered in the progress notes. Multidisciplinary Treatment Plans now include a section for consideration of a patient's Human Rights and Deprivation of Liberty issues. Risk assessments are completed/reviewed by the multidisciplinary team.
Area for Improvement No. 7 **Ref:** Standard 5.3.1(f) **Stated:** First time **To be completed by:** 3 May 2017	The review of risk assessments did not evidence who was present at the review and any changes made and the rationale for these changes.
	Response by responsible person detailing the actions taken: The risk assessment is reviewed at each multidisciplinary team meeting of which a record of attendance is taken. Attendees will not be repeated on the risk assessment document. Risk assessments will be reviewed to ensure that any changes made and rationale for changes is recorded.

Area for Improvement No. 8 **Ref:** Standard 5.3.1 (f) **Stated:** First time **To be completed by:** 3 May 2017	The weekly or monthly checks required (e.g. door closures) did not record the job requests number against comments section to evidence that the appropriate action has been taken.
	Response by responsible person detailing the actions taken: Job requests will now be recorded against the comments section to evidence that the appropriate action has been taken.
Area for Improvement No. 9 **Ref:** Standard 5.3.1(f) **Stated:** First time **To be completed by:** 3 May 2017	The flooring outside the door to the ward at the top of the stairwell was ripped and needs replacement.
	Response by responsible person detailing the actions taken: A job request has been submitted to Estates Services in relation to the replacement of the flooring at the top of the stairwell (C709187).
Area for Improvement No. 10 **Ref:** Standard 5.3.1 (f) **Stated:** First time **To be completed by:** 3 May 2017	The temperature recording of the medication fridge was not logged on a consistent daily basis.
	Response by responsible person detailing the actions taken: The Ward Manager will ensure that a record of this is maintained consistently.
Priority 2	
Area for Improvement No. 11 **Ref:** Standard 5.3.3 **Stated:** First time **To be completed by:** 3 July 2017	There was no evidence that care plans were evaluated.
	Response by responsible person detailing the actions taken: The care planning template is currently being reviewed to include a section for evaluation of same. It is expected that the new template will be fully implemented by 30 June 2017.
Area for Improvement No. 12 **Ref:** Standard 5.3.1(f)	Minutes of the multi-disciplinary team did not reflect the breadth of discussion on patients or the contribution of all disciplines.
	Response by responsible person detailing the actions taken: This recommendation is not feasible and the Trust cannot deliver on

Stated: First time **To be completed by:** 3 July 2017	this. The recording of salient action points will continue to be recorded at each MDT meeting.
Priority 3	
Area for Improvement No. 13 **Ref:** Standard 4.3 (m) **Stated:** First time **To be completed by:** 3 October 2017	Some patients have been admitted with eating disorders and staff stated they had no specific training around the management of eating disorders such as nasal gastric feeding and administrating IV fluids.
	Response by responsible person detailing the actions taken: Staff in Ward J do not insert NG Tubes and there is clear guidance in place as to actions to be taken if a patient pulls their NG tube out. All staff undertaking feeding via an NG Tube have been trained on this. IV fluids are not routinely administered in Acute Mental Health Wards; staff can contact colleagues on the general side of the hospital to assist with this.
Area for Improvement No. 14 **Ref:** Standard 5.3.1 (f) **Stated:** First time **To be completed by:** 3 October 2017	There were not enough fire wardens to have one scheduled on every shift.
	Response by responsible person detailing the actions taken: All staff will be trained as fire wardens by the specified timescale.

Name of person(s) completing the provider compliance plan	Michael Rooney, Ward Manager, Ward J		
Signature of person(s) completing the provider compliance plan		**Date completed**	23/05/2017
Name of responsible person approving the provider compliance plan	Martin Dillon, Chief Executive, Belfast Health and Social Care Trust		
Signature of responsible person approving the provider compliance plan		**Date approved**	23/05/2017
Name of RQIA inspector assessing response	Cairn Magill		
Signature of RQIA inspector assessing response		**Date approved**	02/06/2017

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