Unannounced Follow up Inspection Report
9 – 10 August 2017

Ward K
Mental Health Acute Admissions Ward
Mater Hospital, Crumlin Road, Belfast

Tel No: 0289051537

Inspector: Alan Guthrie

www.rqia.org.uk

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 K is a 20 bedded ward that provides treatment and care to male patients who require assessment and treatment in an inpatient setting. The ward is one of three acute psychiatric wards occupying an old victorian building on the Mater hospital site. Ward K is on the second floor of the building.

Patients on Ward K are supported by nursing, medical, occupational therapy, psychology and social work staff. On the day of the inspection all of the beds were occupied. 11 patients had been admitted to the ward in accordance with the Mental Health (Northern Ireland) Order 1986. Two patients were receiving enhanced continuous support from nursing staff.

3.0 Service details

Responsible person: Martin Dillion	**Ward Manager:** Noel Burke
Category of care: Assessment and Treatment	**Number of beds:** 20
Person in charge at the time of inspection: Noel Burke	

4.0 Inspection summary

An unannounced follow-up inspection took place over two days on 9 – 10 August 2017.

The inspection methodology was to review five areas for improvement identified from the previous unannounced inspection completed on 27 – 29 September 2016. On the days of the inspection the inspector evidenced positive experiences for patients. Staff who met with the inspector stated that they enjoyed working on the ward, felt supported and were part of an inclusive and effective multi-disciplinary team. Inspection findings evidenced three of the five areas for improvement rated by inspectors had been met. One area had been partially met and one area had not been met.

Inspectors noted that the ward had made positive progress in addressing all the areas for improvement identified as a result of the previous inspection. The facilities gym had been updated and patients could use it upon request to staff. The trust had reviewed its no smoking policy (for those patients who smoke and present with an accute psychiatric illness). This had resulted in the provision of clear guidelines and procedures for staff when supporting patients who smoke.

The area for improvement in relation to mandatory training was assessed as partially met. The ward manager continued to closely monitor the mandatory training needs of the nursing staff. It was good to note that the ward manager had clear oversight of each staff member's training

achievements and deficits. The inspector noted that a number of factors had impacted on the completion of staff training these included:

- Reconfiguration of training by the trust (for example increased numbers of staff requiring fire warden training and timelines between training being reduced).
- Increased numbers of patients requiring continuing support resulting in greater numbers of nursing staff being required for each shift).
- Staff sickness.
- Changes in the trust's staff appraisal process.

Staff who met with the inspector reported no concerns regarding their ability to access training. The inspector also evidenced that a number of training courses had been booked. However, training records reviewed by the inspector detailed deficits in mandatory training and in the completion of staff appraisals. This area for improvement has been restated for a second time in the provider compliance plan accompanying this report..

One area for improvement was assessed as not met. Onward referral procedures for patients leaving the ward remained difficult to navigate and had previously caused delays in patients being discharged from the ward. The inspector evidenced that ward staff were required to manage the referral of patients to trust community teams through a range of different referral systems. These included making referrals by phone, hand written referrals and referrals through the trust's PARIS electronic information system. The inspector also reviewed copies of four different referral forms and associated processes. This area for improvement has been restated for a second time in the provider compliance plan accompanying this report.

Patients stated

The inspector met with four patients. Patients were positive about the ward and their relationships with staff. Patients stated that they felt safe and secure on the ward, understood their rights and staff had listened to them and treated them with dignity and respect. Inspectors evidenced no concerns regarding the care and treatment provided to patients.

The inspector observed staff to be available throughout the ward during both days of the inspection. Interactions between patients and staff were evidenced as being respectful, supportive and patient centred. Patients moved freely throughout the ward and patient requests were dealt with promptly and appropriately. Patients who met with the inspector reported that they had no concerns when requesting support from staff.

Patient comments included:

"Staff are very good".

"There are lots of things to do around the ward".

"Best ward I have ever been in…I've been in plenty".

"Good staff".

"I have no problems with the ward".

"I am listened to and respected".

"The ward has a co-operative atmosphere".

"The sandwiches and soup aren't up to much".

"Everythings dead on".

"Staff are very good".

Relatives stated

The inspector met with one relative. The relative reported no concerns regarding the care and treatment provided to patients. The relative stated that they felt the ward was welcoming and staff were approachable and easy to talk to. The relative was very complementary regarding the flexible visiting hours and the relaxed atmosphere within the ward.

Staff stated

Inspectors met with seven members of ward staff.

Staff reported that they felt the multi-disciplinary team (MDT) worked well together and that everyone's views were considered. It was positve to note that staff enjoyed working on the ward. Staff said that they felt listened to and supported by colleagues and the ward's senior management team. Staff stated that they felt the care and treatment provided to patients on the ward was good. Staff felt the ward was safe and that the care and treatment provided by the MDT was patient centred and effective.

Staff reported no concerns regarding the levels of nursing staff available. Staff informed the inspector that they had no concerns about their ability to access training and supervision.

Staff comments included:

"I enjoy working here".

"The ward has a supportive MDT ".

"This is a great staff team… very supportive".

"Staff here are brilliant with patients".

"The wards very relaxed".

"Staff are very friendly".

"This has been a good experience (student nurse)".

"Everyones approachable".

"The ward has an inclusive ward round ".

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	2

The total number of areas for improvement comprise of two areas for improvement being restated for a second. No new areas for improvement were 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, 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

6.0 The inspection

The following areas were examined during the inspection:

- Care documentation in relation to four patients
- Ward environment
- Advocacy service
- Minutes of staff meetings
- Records in relation to incidents and accidents
- Staff supervision and appraisal dates
- Staff training
- Staff duty rotas
- Medication prescription sheets
- Complaints and compliments
- Information in relation to safeguarding vulnerable adults
- Minutes from governance meetings

6.1 Review of areas for improvement from the last unannounced inspection

The most recent inspection of Ward K 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.

Areas for Improvement		Validation of Compliance
Area for improvement 1 **Ref**: Standard **Stated:** First Time	The responsible person must ensure that the facilities gym is refurbished and reopened for patient use.	**Met**
	Action taken as confirmed during the inspection: The inspector reviewed the facilities gym located on the ground floor of the building. Inspectors noted that the gym had been refurbished and new exercise equipment had been installed. Patients who met with the inspector stated that they could access the gym upon request to staff.	
Area for improvement 2 **Ref**: Standard **Stated:** First Time	The responsible person must review the implementation of the trust's no smoking policy for those patients who smoke and present with acute psychiatric illness.	**Met**
	Action taken as confirmed during the inspection: The trust had reviewed its no smoking policy (for those patients who smoke and present with an accute psychiatric illness). This had resulted in the provision of clear guidelines and procedures for staff when supporting patients who smoke. The inspector reviewed the guidance and noted that it was appropriate to the needs of the patient group. The guidance also provided staff with the necessary autonomy to ensure patient safety.	
Area for improvement 3 **Ref**: Standard **Stated:** First Time	The responsible person must ensure that referral to community mental health services for patients discharged from Ward K is clear, easy to navigate, is appropriately time bounded and commensurate to the needs of each patient.	**Not met**
	Action taken as confirmed during the inspection: Onward referral procedures for patients leaving the ward remained difficult to navigate and had previously caused delays in patients being discharged from the ward. The inspector evidenced that ward staff were required to manage	

	the referral of patients to trust community teams through a range of different referral systems .These included making referrals by phone, hand written referals and referrals through the trust's PARIS electronic information system. The inspector also reviewed copies of four different referral forms and associated processes. Nursing staff who spoke with the inspector stated that there were ongoing challenges in making appropriate and timely onward referrals for patients ready to leave the ward.	
Area for improvement 4 **Ref**: Standard **Stated:** First time	The responsible person must ensure the procedures relating to the implementation of the trust's no smoking policy are appropriately detailed and clearly stated. The procedures should ensure that the staff team can manage smoking for those patients presenting with acute psychiatric illness, associated significant risk factors and or a lack of capacity.	**Met**
	Action taken as confirmed during the inspection: The inspector reviewed the trusts proceudres form implementing the no smoking policy within mental health acute care wards. The inspector assessed the procedures as appropriate in accordance to the assessed needs of the patient group.. Staff who met with the inspector reported no concerns with regard to managing incidents of smoking within the ward.	
Area for improvement 5 **Ref**: Standard **Stated:** First Time	The responsible person must ensure that nursing staffs mandatory training is completed in accordance to trust policy.	**Partially met**
	Action taken as confirmed during the inspection: Nurse training records reviewed by the inspector evidenced that the ward manager continued to closely monitor the mandatory training needs of nursing staff. It was good to note that the ward manager had clear oversight of each staff members training achievements and deficits. However, the inspector noted deficits in relation to staff appraisals and mandatory training.	

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 to Team.MentalHealth@rqia.org.uk for assessment by the inspector by 05 October 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 (a) **Stated:** Second time **To be completed by:** 10 February 2018	The responsible person must ensure that referral to community mental health services for patients discharged from Ward K is clear, easy to navigate, is appropriately time bounded and commensurate to the needs of each patient.		
	Response by responsible person detailing the actions taken: This is currently being reviewed at Senior Management Team level and a solution will be found within the inspector's stated timeframe.		
Area for Improvement No. 2 **Ref:** Quality Standard 5.3.3(d) **Stated:** Second Time **To be completed by**: 10 February 2018	The responsible person must ensure that nursing staff mandatory training is completed in accordance to trust policy		
	Response by responsible person detailing the actions taken: All nursing staff mandatory training including their yearly appraisals will be updated within the inspectors stated timescale.		
Name of person (s) completing the PCP	Mel Carney, Service Manager, Acute Mental Health Services Cahal McKervey, Operations Manager, Acute Mental Health Services Noel Burke, Charge Nurse, Ward K Patricia Minnis, Quality and Information Manager		
Signature of person (s) completing the PCP	As above	**Date completed**	29/09/2017
Name of responsible person approving the PCP	Martin Dillon		
Signature of responsible person approving the PCP	Martin Dillon	**Date approved**	29/09/2017
Name of RQIA inspector assessing response			
Signature of RQIA inspector assessing response	Alan Guthrie	**Date approved**	10 October 2017

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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