Mental Health and Learning Disability Inpatient Inspection Report
27 – 29 September 2016

Ward K
Mental Health Acute Admissions Ward

Mater Hospital, Crumlin Road, Belfast
Tel No: 0289051537

Inspectors: Alan Guthrie, Dr Brian Fleming

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. Four patients had been admitted to the ward in accordance with the Mental Health (Northern Ireland) Order 1986.

3.0 Service Details

Responsible person: Martin Dillon	**Position:** Deputy Chief Executive
Ward manager: Noel Burke	
Person in charge at the time of inspection: Noel Burke	

4.0 Inspection Summary

An unannounced inspection took place over a period of three days from the 27 to 29 September 2016.

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 K 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 provided patient centred care.
- The multidisciplinary team (MDT) was well led and effective.
- The staff team worked well together.

Areas requiring improvement were identified. One priority two area for improvement has been made. This concern relates to the refurbishment and reopening of the facilities gym. Four priority three areas for improvement have also been identified. These areas include a review of the Trust's smoking policy, relative to mental health acute admission wards, and a review of procedures related to the management of smoking and patient and staff safety. Priority three concerns were also made regarding patient discharge pathways and staff training.

Patients Stated:

During the inspection inspectors met with four patients. Each of the patients completed a questionnaire. Patients stated that the staff were approachable, easy to talk to and supportive. All of the patients stated that they were treated with dignity and respect and had felt better since being admitted to the ward.

Patient involvement in their care and treatment was observed by inspectors. Staff were observed asking patients for their consent prior to providing the patient with support.

Throughout the inspection the atmosphere on the ward was observed to be welcoming, calm and relaxed. Staff were available throughout the ward's main areas and patient requests were responded to quickly and in an appropriate manner.

Patients Said:

"It's a great ward…excellent".

"Staff are really good and down to earth".

"Staff bend over backwards for you".

"Pretty good…pretty clean".

"Staff attitude is more good than not".

"I enjoy the social aspect".

"Most of the staff are o.k".

"It's alright…staff are very helpful".

"Smoking…should be sorted".

During the inspection patients' relatives were invited to meet with an inspector. No relatives were available to meet with an inspector.

Staff Stated:

Inspectors met with ten members of the ward's MDT incorporating the views of clinical and support staff. Staff told inspectors that they enjoyed working on the ward and that they felt their work and opinion was valued and considered. Staff were complimentary regarding their experience of the MDT. Staff informed inspectors that they felt the ward provided a patient centred approach and the care and treatment interventions were effective.

The ward management team was described as inclusive, approachable and solution focussed. Staff reported no concerns regarding their ability to access training, appraisal and supervision.

Inspectors met with five members of nursing staff. Staff presented as motivated and patient centered. It was positive to note, at the time of the inspection, there was no staff sickness. Staff reported no concerns regarding their role and responsibilities. Inspectors noted that nursing staff demonstrated appropriate knowledge, skills and understanding regarding the ethos of the ward and the presenting needs of patients.

All staff who met with inspectors stated that the two most significant challenges to their role related to the implementation of the Trust's no smoking policy and the management of patient discharges to community teams. Both these issues are discussed in the provider compliance plan. Patients and staff informed inspectors that implementing the Trust's no smoking policy within Ward K was adversely affecting patient care and increasing patient anxiety. Inspectors evidenced that smoking was being driven underground with patients smoking in the toilet and

shower areas. Whilst staff were monitoring this and positively challenging patients caught smoking inspectors were concerned that illicit smoking and risk of fire had increased. Inspectors noted that due to the design of the building and its location it was not feasible or appropriate for staff to accompany patients out of the hospital grounds to have a smoke break. Accompanying acutely unwell patients and patients who lacked capacity off hospital grounds increased the risks for both the patient and staff, particularly as the ward is adjacent to a busy thoroughfare.

Medical staff stated that ward processes were effective and the ward benefitted from good leadership and a supportive patient centred MDT. Medical staff reported no concerns regarding the governance of the ward's care and treatment practices. It was positive to note that working relationships within the MDT were described as very good. Staff also stated that the ward's senior management team meetings had further developed and as a result of this clinicians were attending a greater number of management meetings. These included governance meetings, incident review meetings and acute inpatient quality improvement meetings.

Staff Said:

"It's an enthusiastic and supportive team. I really enjoy working here".

"It's a good ward that runs effectively".

"The ward management is very good".

"I really enjoy working on the ward".

"Managers listen to ideas".

"I feel safe working here".

"Discharging patients is challenging. It's not always clear which team will provide the required support."

"I have had very positive experiences with Trust community teams."

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	Five

Findings of the inspection were discussed with Ward K's management team 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

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

- The operational policy or statement of purpose for the ward.
- 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 four patients and ten staff.

The following records were examined during the inspection:
Care documentation in relation to four patients.

- Multi-disciplinary team records
- Policies and procedures
- Staff roster
- Staff supervision timetable
- Clinical room records
- The Trust's PARIS electronic record system
- Complaints
- Incidents, accidents and serious adverse incident records
- Staff rota
- Training records.

During the inspection the inspector observed staff working practices and interactions with patients using a Quality of Interaction Schedule Tool (QUIS).

The inspector reviewed the recommendations made at the last inspection. An assessment of compliance was recorded as 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 from the most recent inspection dated 17/08/2015

The most recent inspection of Ward K was an unannounced inspection. The completed quality improvement plan (QIP) was returned and approved by the responsible inspector. This was validated by the responsible inspector during this inspection.

Follow up on Previous Inspection Recommendations

Six recommendations were made following the most recent inspection on 7 August 2015. All of the recommendations had been implemented in full.

1. The Trust had completed an up to date assessment of the ward's environment and ligature risks in June 2016. The ligature review included a recommended action plan. The plan had been implemented and continued to be flexible in accordance with the assessed needs of each patient.

2. The Trust had completed a ligature risk review and assessment in June 2016. Inspectors evidenced that ligature issues noted on the review included appropriate recommendations regarding required actions and management of identified ligature points.

3. Risk assessments reviewed by inspectors evidenced that each patient was assessed in accordance with their individual presentation and associated needs. This included assessment and care planning for individuals at risk from potential use of a ligature point.

4. The ward had reintroduced a resuscitation trolley. Records reviewed by inspectors evidenced that the emergency equipment retained within the trolley was reviewed on a daily basis. The resuscitation trolley was also audited by the Ward Manager on a weekly basis.

5. Each of Ward K's bathroom and toilet areas had been refurbished. The refurbishment included new flooring and wall panelling. Inspectors noted the substantial improvements made to the bathroom area as a result of this work.

6. Patient information was maintained and managed in an appropriate and confidential manner. The patient information board had been replaced with a new board which included doors so that personal information would not be seen by visitors to the ward or other patients. This also allowed staff to view information confidentially.

6.2 Review of findings

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

Inspectors evidenced the completion of appropriate and comprehensive risk assessments within each set of patient records reviewed.

Risk assessments reviewed by inspectors were noted to be individualised, based on the assessed needs of each patient and reviewed regularly by the ward's multi-disciplinary team.

Environmental risk assessments completed in relation to Ward K were noted to be comprehensive, up to date and specific to Ward K.

Staff who met with inspectors stated that they had confidence in the ward's processes for safeguarding vulnerable adults and children.

Patients reported no concerns regarding their ability to access the ward's complaints processes.

Patients admitted to the ward in accordance to the Mental Health (Northern Ireland) Order 1986 were being managed in accordance to the legislative requirements.

Inspectors evidenced that the ward promoted a least restrictive environment.

Areas for Improvement

The Trust must review the implementation of the no smoking policy particularly for those patients who smoke and present with acute psychiatric illness or diminished capacity.

Number of areas for improvement	One

6.3 Is Care Effective?

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

Areas of Good Practice

The needs of patients were comprehensively assessed.

Patients stated that they felt better since their admission.

Inspectors evidenced that the MDT worked effectively.

Care and treatment interventions were based on the individual needs of each patient.

The ward provided an appropriate range of evidenced based treatment interventions.

The Trust was continuing to develop its electronic patient information system.

Patients could access specialist services as required. This included psychology, social work and dietetics.

The ward's senior management team were reviewing discharge care pathways and patient access to specialist community teams.

Areas for Improvement

The Trust Referral pathways to specialist community based teams were complex, time consuming and, on occasion, poorly coordinated with a patient's discharge. It was good to note that patient care pathways involving a number of different community teams were being reviewed by the Trust's senior management team.

Number of areas for Improvement	One

6.4 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

Staff treated patients with dignity and respect.

The atmosphere within the ward during the inspection was relaxed and staff remained approachable.

Patients were given the opportunity to have a family member/representative attend meetings regarding their care and treatment.

Patients were kept informed regarding their care and treatment. Patients reported no concerns regarding their ability to meet with staff involved in their care and treatment.

The use of restrictive practices was evidenced as being appropriate and based on the assessed needs of the patient.

Patients could access independent advocacy services as required.

Ward staff were compassionate and supported patients in a pragmatic, measured and appropriate member. This approach is to be commended particularly as staff continued to promote best practice regarding the Trust's no smoking policy.

Areas for Improvement

The procedures relating to the implementation of the Trust's no smoking policy for patients presenting with psychotic symptoms or diminished capacity were not clear. The current smoking procedures require to be reviewed and staff should be supported in this regard. This issue is further compounded by the fact that there are no suitable locations away from hospital property where patients who smoke can be facilitated.

The gym in The Mater required repairs and refurbishment of equipment. It was good to note that a timeline of three months to oversee necessary works to the gym before it is reopened had been agreed.

Number of areas for Improvement	Two

6.5 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

Staff who met with inspectors stated that they were happy working on the ward and that they felt supported.

Inspectors evidenced that the ward staff team implemented appropriate governance processes to help safeguard patients.

The ward manager had clear oversight of nursing staff training, supervision and appraisal.

There was clearly defined organisational and management structures.

Ward staff demonstrated a high level of skills and awareness regarding their role and responsibilities.

The ward's clinical room and procedures for the storing of medication were maintained to the required standard.

Staff stated that relationships within the MDT were positive, supportive and effective.

Areas for improvement

Inspectors evidenced mandatory training deficits in annual fire training, medication management, manual handling and the Trust's health and safety training.

Number of areas for Improvement	One

7.0 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.

7.1 Areas for improvement

This section outlines recommended actions, to address the areas for improvement identified, based quality care standards, MHO and relevant evidenced based practice.

7.2 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.

Provider Compliance Plan Ward K	
Priority 1	
Area for Improvement	No priority one areas for improvement were identified during this inspection.
Priority 2	
Area for Improvement No. 1 **Stated:** First time **To be completed by:** 28 December 2016	The responsible person must ensure that the facilities' gym is refurbished and reopened for patient use.
	Response by responsible individual detailing the actions taken: Monies have been secured for the refurbishment of the gym. A meeting is taking place with a contractor w/c 07 November 2016 to discuss the current gym equipment. All equipment will be serviced or replaced as required.
Priority 3	
Area for Improvement No. 2 **Stated:** First time **To be completed by:** 28 March 2017	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 or diminished capacity.
	Response by responsible individual detailing the actions taken: RQIA will be aware that the Belfast Trust is adhering to regional guidance produced by the Department of Health. The above issue has been raised with the Director of Nursing for the Belfast Trust and a response is awaited.
Area for Improvement No. 3 **Stated:** First time **To be completed by:** 28 March 2017	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: Staff in Ward K will adhere to the Discharge Guidance to ensure that discharge for patients is appropriately time bounded and commensurate to their needs. The Mental Health Senior Management Team are currently considering a paper setting out changes to the role of the Hospital Social Work Service which will impact on this area of work.
Area for Improvement No. 4 **Stated:** First time **To be completed by:** 28 March 2017	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.
	Response by responsible person detailing the actions taken:

	New guidance has been drafted for staff in relation to implementing the Trust's no smoking policy. This will be provided to Inspectors upon request.
Area for Improvement No. 5 **Stated:** First time **To be completed by:** 28 March 2017	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: Staff continue to be facilitated to attend their mandatory training. Training will be completed in accordance to the Trust policy by the specified timescale.

Name of person completing the provider compliance plan	Noel Burke		
Signature of person completing the provider compliance plan	Noel Burke	**Date completed**	04/11/2016
Name of responsible person approving the provider compliance plan	Martin Dillon		
Signature of responsible person approving the provider compliance plan	Martin Dillon	**Date approved**	04/11/2016
Name of RQIA inspector assessing response	Alan Guthrie		
Signature of RQIA inspector assessing response		**Date approved**	5 January 2017

7.0 Provider compliance plan

There were no areas for improvement identified during this inspection, and a provider compliance plan is not required or included, as part of this inspection report.

The Regulation and Quality Improvement Authority

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