Mental Health and Learning Disability Inpatient Inspection Report 24 – 25 July 2018

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

Tel No: 028 95046425

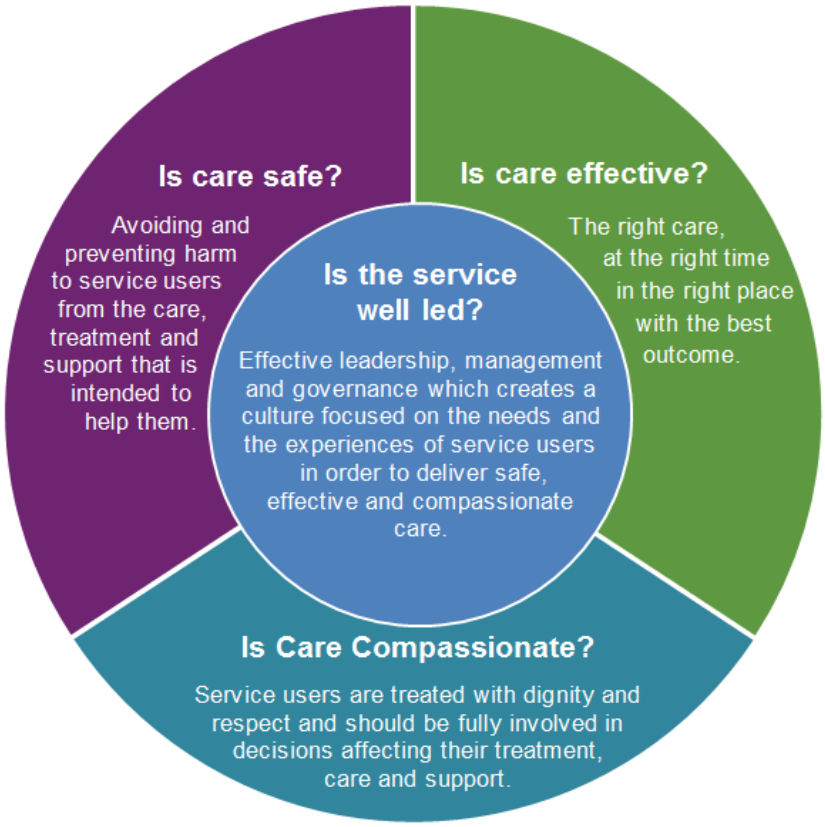
Inspectors: Alan Guthrie and Dr John Simpson

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 care and treatment 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 days of the inspection 19 patients were admitted to the ward. Seven 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:** 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 two days from the 24 to 25 July 2018.

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 ward was quiet and calm and patients presented as being at ease in the ward.
- Patients who met with inspectors stated that staff were helpful and easy to talk to.
- The staff team worked well together.

Areas requiring improvement were identified. Four areas for improvement have been made. Two areas relate to patient care and treatment pathways. The remaining two areas relate to recording of patients nutritional needs and the use of physical interventions. Findings from this inspection resulted in escalation in accordance to RQIA escalation policy and procedures. An escalation meeting was convened on the 8 August 2018. The outcome of the escalation meeting is discussed in section 4.2 of this report.

During the inspection inspectors also noted that the ward was providing care and treatment to two patients who had palliative care needs. Inspectors were concerned that the care and treatment being provided to both these patients required review, with a view to confirming the discharge/transfer arrangements. It is important to highlight there may be a more suitable environment to meet the physical health needs of these patients.

Inspectors evidenced that two sets of patient care records had not been completed in accordance to the required standards. One patient's Malnutrition Universal Screening Tool MUST assessment had not been scored and had not been completed weekly as indicated. A

subsequent MUST assessment was completed identifying the patient as being at high risk. Inspectors were concerned that the use of a MUST assessment for the patient had not been completed in accordance to the required standards. Inspectors also evidenced that there were two care plans within the patient's file. One had been completed by ward K staff and the other by the general hospital. The presence of two care plans is not in keeping with best practice.

Inspectors were concerned that the care and treatment of another patient was not been carried out in accordance to trust policy and procedures. The patient presented with significant mental health (detained under the MH order) and physical health problems. The patient required ongoing observation and support with drinking and eating. The patient had been assessed as lacking capacity and required the support of four/five staff during meal times. Staff were required to use restraint as the patient was resistive to receiving fluids and during meal times the patient became resistive and aggressive. It is important to note that staff were observed providing a high standard of care and treatment to the patient. However, inspectors noted the following concerns in relation to recording:

- The patient's MUST assessment was not completed in full.

- The patient's daily fluid balance sheets were not completed in full. Inspectors evidenced inconsistent recording of the patient's fluid intake. For example daily nutritional intake was recorded on a meal to meal basis on some daily entries and in total on others.

- Use of restraint records (Managing Actual and Potential Aggression) were not being completed and these interventions were not being reported as incidents. This is contrary to trust policy and procedures. Whilst it is important to note that the completion of up to seven sets of restraint records and four incident reports daily would not be pragmatic or best use of staff time. Inspectors were concerned that the rationale for providing the intervention and not completing the associated records was not clear. Given the patient was being cared for in an open ward where other patients and visitors witnessed the patient's verbal resistance and staff interventions inspectors noted the potential for challenge regarding the use of restraint. Inspectors were not assured that safeguarding protocols had been properly implemented.

These areas of concern are discussed in the quality improvement plan within this report.

Patients stated

Inspectors met with five patients. Three 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.

Throughout the inspection the atmosphere on the ward was observed to be welcoming and calm. Staff were available throughout the ward's main areas and patient requests were responded to quickly and in an appropriate manner. Although the ward was limited for space patients and staff were observed as having positive relationships. Patients who met with inspectors reflected positively regarding their experience of the ward and the care and treatment

they were receiving. Patients reported no concerns regarding their involvement in their care and treatment plans.

Patient comments included:

"I have been treated fantastic."

"It's OK."

"Foods OK."

"Nothing I would change."

"There seems to be enough staff."

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 eleven members of the ward's multi-disciplinary team (MDT) incorporating the views of clinical and support staff. Staff stated that they felt the care and treatment provided to patients admitted to the ward was patient centred and effective. Staff stated that they felt the care provided was of a high standard.

Nursing staff reported no concerns regarding their ability to access supervision and training. Staff stated that the ward's management team were supportive and approachable. The ward's MDT was described as inclusive and patient focussed and it was positive to note that staff felt the care and treatment provided to patients within ward K was of a high standard. Nursing staff stated that the presenting physical health needs of some patients presented challenges to the MDT.

Members of the MDT who met with inspectors discussed the current challenges to their role, specifically managing the complex needs of two patients presenting with physical health and palliative care needs. Staff stated that both patients required intensive support and specific care and treatment interventions. This included physical health care interventions, continue close observation and use of restrictive practices with one patient. Some staff reflected that they felt the ward was not the most appropriate location for one patient. RQIA inspectors discussed this with the ward's senior management team at a serious concerns meeting on the 9 August 2018. The outcomes from the meeting are discussed below.

Staff comments included

"One patient can require the support of five staff and sometimes we have to run short (of staff)…basic nursing care is done."

"All care is being given to patients I have no concerns."

"Patients using illicit drugs on the ward…can be difficult to manage."

"Overall needs of patient are being met…good care though staffing shortages can have an impact…care is safe".

"Staff have a good ethos…the approach (of staff) are all the same, empathic and really caring."

"The ward's environment is limited."

"Sometimes we have staff shortages although basic care needs are being met."

"Normal staffing levels are o.k. on occasion can be short this does happen from time to time."

"Good communication between the MDT."

"Care is compassionate."

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	4

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 resulted from the findings of this inspection.

The escalation policies and procedures are available on the RQIA website.
https://www.rqia.org.uk/who-we-are/corporate-documents-(1)/rqia-policies-and-procedures/

4.2 Action/enforcement taken following the most recent care inspection dated 24 and 25 July 2018.

Following this inspection a serious concerns meeting was held at RQIA on 9 August 2018 with senior trust representatives. This meeting was held to give the trust representatives the opportunity to discuss one area of improvement they had failed to improve for a third time and to discuss concerns regarding the management of patients requiring palliative care. The outcome of the inspection and the trust's action plan to address the serious concern were also discussed.

It was positive to note that the area for improvement identified by inspectors for a third time had been addressed in full by the trust. The trust confirmed that records from the CEC training matrix available during inspection were inaccurate and not up to date. Safeguarding training for two members of ward staff was not up to date, not six as noted on the day of inspection. The

trust advised RQIA that systems are now in place to ensure that the ward's training matrix is updated on a monthly basis by the Nurse Development Lead and the Charge Nurse. The Trust is now reviewing the failsafe arrangements put in place as a result of RQIA's previous recommendations in this regard. Both members of ward staff have now been booked in to receive safeguarding training on 18 October 2018.

The trust explained that they had recently introduced a new patient care pathway; Patient Purposeful Admission (PPA). PPA methodology includes daily review by the MDT of each patient's circumstances and progress. RQIA was informed that the trust intends to introduce PPA across its mental health acute care services in the near future.

The trust advised that care and treatment arrangements for patients requiring palliative care had been reviewed. The trust assured RQIA that appropriate arrangements had been made for each patient including the discharge of one patient. The trust advised that this was an unusual circumstance, however the psychiatry wards worked closely with general hospital (the Mater), with robust in-reach into wards, so that staff can continue to manage both the physical and mental health needs of patients. The Trust confirmed they would look at interface between mental health and general nursing and identify suitable systems to ensure mental health staff are appropriately supported in the future.

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 inspectors 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 inspectors observed staff working practices and interactions with patients using a Quality of Interaction Schedule Tool (QUIS).

Inspectors 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 ward's management team at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 8-9 August 2017

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.

6.2 Review of Areas for Improvement / Recommendations from Last Inspection dated 8 – 9 August 2017

Areas for Improvement		**Validation of Compliance**
Number/Area 1 **Ref**: Quality Standard 5.3.1(a) **Stated:** Second 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.	Met
	Action taken as confirmed during the inspection: The inspector evidenced that the trust had taken steps to address this area for improvement. This included a single point of referral managed via a single referral form. The inspector was informed that the referral form is being developed on the trust's PARIS (electronic patient information) system. Given the progress made and the fact that a new system is being introduced this area for improvement has been assessed as met. A new area of improvement regarding the implementation of the new referral process has been made. Inspectors noted no concerns regarding patients being able to engage with services upon their discharge from the ward.	

Number/Area 2 **Ref**: Quality Standard 5.3.3 (d) **Stated:** Second Time	The responsible person must ensure that nursing staff mandatory training is completed in accordance to trust policy	Met
	Action taken as confirmed during the inspection: On the day of the inspection inspectors noted that that nursing staff training records evidenced that 6 of the ward's 25 nursing staff had not completed up to date safeguarding training. During a subsequent serious concerns meeting (detailed above) the trust provided assurances and evidence that 23 staff had received training and two staff were booked on training in October 2018.	

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

- Patients stated that they felt safe and that staff were helpful.
- Patients reported feeling better since being admitted to the ward.
- Patient care and treatment plans were based on their assessed needs.
- Patient care records were updated daily and the MDT continued to closely monitor each patient's progress.
- The ward's environmental and ligature risk assessments were up-to-date.
- Inspectors observed staff providing a high standard of care to patients.
- Staffing on the ward's MDT was appropriate to the needs of the patients.
- Inspectors observed staff as being supportive, responsive and available to patients.

Areas for improvement

- Care pathways for patients requiring palliative care within an acute mental health care setting were not clear.

- The use of physically restrictive practices with one patient was not being recorded in accordance to the trusts standards.

Number of areas for improvement	Two

6.3 Is care effective?

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

Areas of good practice

- Patients stated that they felt better since being admitted to the ward.
- Patients' needs were comprehensively assessed.
- Patients could access specialist assessments and treatments from the general hospital.
- Staff continually reviewed each patient's progress.
- Patients were positive and complementary regarding their experience of the ward.
- The ward's management team continued to develop patient discharge planning processes with trust community teams and services.

Areas for improvement

- Patient's fluid balance records were not being completed in accordance to the required standards.

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

- Patients stated that staff treated them with dignity and respect.
- Inspectors observed staff responding compassionately to patient need.
- Patients were involved in their care and treatment plans.

- Patients who spoke with inspectors were satisfied with the care and treatment being provided by ward staff.
- Care and treatment options were discussed with the patient and their family/representatives.
- Patients could access an independent advocate as required.
- Inspectors observed staff to be patient centred, motivated and skilled.

Areas for improvement

No areas for improve relating to is care compassionate were identified as a result of this inspection.

Number of areas for improvement	None

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 reported no concerns regarding their ability to access supervision, training and appraisal.
- Staff who met with inspectors described the MDT as being patient focussed and inclusive.
- Inspectors were informed that relationships within the MDT were good.
- Staff who met with inspectors described the ward as being a positive and good place to work.
- Patients reported no concerns at being able to meet with MDT staff involved in their care and treatment.

Areas for improvement

- No areas for improve relating to is care compassionate were identified as a result of this inspection.

Number of areas for improvement	None

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	
Area for Improvement No. 1 **Ref:** Quality Standard 5.3.1 (a) **Stated:** First time **To be completed by:** 25 October 2018	It is recommended that the trust introduces a single referral pathway for patients leaving the ward and requiring care and support from the trust's community mental health team(s).
	Response by responsible individual detailing the actions taken: Two Clinical Services Managers have been appointed for Community Mental Health Teams. All referrals from Wards to the Community will be processed by the Clinical Services Managers
Area for Improvement No. 2 **Ref:** Quality Standard 5.3.1 (a) **Stated:** First time **To be completed by:** 25 January 2019	It is recommended that care pathways for patients requiring palliative care within an acute mental health care setting are clearly defined. This includes, where necessary, the involvement of general nursing staff in the patient's care and treatment.
	Response by responsible individual detailing the actions taken: The Divisional Nurse for Mental Health and the Belfast Trust Palliative Care Leads are in the process of developing a care pathway for patients in acute mental health settings who require palliative care. This will be in place by 25 January 2019.
Area for Improvement No. 3 **Ref:** Quality Standard 5.3.1 (f) **Stated:** First time **To be completed by:** 25 September 2018	The use of physical interventions (managing actual and potential aggression) must be managed and recorded in accordance to trust and regional standards.
	Response by responsible person detailing the actions taken: A care plan was created for the gentleman in question in keeping with the Trust's Restrictive Practices Procedure. All staff have been advised of the need to complete an incident form each time restraint is used in line with Trust policy.
Area for Improvement No. 4 **Ref:** Quality Standard **Stated:** First time **To be completed by:** 25 September 2018	The monitoring and recording of patients' nutritional needs must be completed in accordance to the required standards.
	Response by responsible person detailing the actions taken: Ward K staff have been re-issued with the Trust's fluid and nutrition policy. Refresher training on the use of MUST is also being organised for staff by the Acute Mental Health Services NDL.

Name of person completing the provider compliance plan	———Anne McDonnell, Consutant Psychiatrist Paul McCabe, Operations Manager Johnny Killough, Senior Nurse Manager Noel Burke, Charge Nurse, Ward K Patricia Minnis, Quality and Information Manager		
Signature of person completing the provider compliance plan		**Date completed**	———05/10/2018
Name of responsible person approving the provider compliance plan	———Martin Dillon, Chief Executive		
Signature of responsible person approving the provider compliance plan		**Date approved**	——— ———
Name of RQIA inspector assessing response	———Alan Guthrie		
Signature of RQIA inspector assessing response		**Date approved**	———21 November 2018

The Regulation and Quality Improvement Authority

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