The Regulation and Quality Improvement Authority

Ward L

Mater Hospital

Belfast Trust

Unannounced Inspection Report

Date of inspection: 17 April 2015

npm national preventive mechanism

informing and improving health and social care

www.rqia.org.uk

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Our Vision, Purpose and Values

Vision

To be a driving force for improvement in the quality of health and social care in Northern Ireland

Purpose

The Regulation and Quality Improvement Authority (RQIA) is the independent health and social care regulator in Northern Ireland. We provide assurance about the quality of care, challenge poor practice, promote improvement, safeguard the rights of service users and inform the public through the publication of our reports.

Values

RQIA has a shared set of values that define our culture, and capture what we do when we are at our best:

- **Independence** - upholding our independence as a regulator
- **Inclusiveness** - promoting public involvement and building effective partnerships - internally and externally
- **Integrity** - being honest, open, fair and transparent in all our dealings with our stakeholders
- **Accountability** - being accountable and taking responsibility for our actions
- **Professionalism** - providing professional, effective and efficient services in all aspects of our work - internally and externally
- **Effectiveness** - being an effective and progressive regulator - forward-facing, outward-looking and constantly seeking to develop and improve our services

This comes together in RQIA's Culture Charter, which sets out the behaviours that are expected when employees are living our values in their everyday work.

Contents

1.0 Introduction

The Regulation and Quality Improvement Authority (RQIA) is the independent health and social care regulator in Northern Ireland. We provide assurance about the quality of care, challenge poor practice, promote improvement, safeguard the rights of service users and inform the public through the publication of our reports.

RQIA's programmes of inspection, review and monitoring of mental health legislation focus on three specific and important questions:

Is Care Safe?

- Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them

Is Care Effective?

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

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

2.0 Purpose and Aim of this Inspection

To review the ward's progress in relation to recommendations made following previous inspections.

To meet with patients to discuss their views about their care, treatment and experiences.

To assess that the ward environment is fit for purpose and delivers a relaxed, comfortable and safe.

To evaluate the type and quality of communication, interaction and care practice during a direct observation using a Quality of interaction Schedule (QUIS).

2.1 What happens on inspection

What did the inspector do?

- reviewed the quality improvement plan sent to RQIA by the Trust following the last inspection(s)

- talked to patients, carers and staff
- observed staff practice on the days of the inspection
- looked at different types of documentation

At the end of the inspection the inspector:

- discussed the inspection findings with staff
- agreed any improvements that are required

After the inspection the ward staff will:

- send an improvement plan to RQIA to describe the actions they will take to make any necessary improvements

3.0 About the ward

Ward L is a fourteen bedded acute psychiatric inpatient facility. It is a mixed gender ward providing care and treatment to patients over 65 years and to patients from age 18, admitted for treatment in accordance to the Mental Health (Northern Ireland) Order 1986.

The ward is staffed by a multi-disciplinary team which includes medical, nursing, social work and occupational therapy staff. It is situated on the third floor of the psychiatric department and provides a combination of en suite single rooms and dormitory accommodation.

On the day of the inspection the ward was at full capacity and six of the patients had been admitted in accordance with the Mental Health (Northern Ireland) Order 1986. One patient was receiving one to one observations.

4.0 Summary

Progress in implementing the recommendations made following the previous inspection carried out on 5 and 6 August 2014 were assessed during this inspection. There were a total of 12 recommendations made following the last inspection.

It was good to note that all 12 recommendations had been implemented in full.

Recommendations in relation to the multi-disciplinary team and ward staff meetings had been implemented and the inspector evidenced that staff could access these meetings on a regular basis. A monthly clinical governance meeting had also been introduced. Minutes from previous governance meeting evidenced that incidents occurring on the ward were discussed and reflected upon. It was positive to note that the outcome of these meetings was disseminated to all ward staff. Staff who met with the inspector reported that they felt the ward's multi-disciplinary team was supportive and effective.

It was good to note that the Trust had updated the policy and procedures for supporting young people admitted to the ward. The Trust had also introduced a protocol to guide staff regarding the admission and discharge of patients within each of the three psychiatric wards located on the Mater hospital site. The protocol recorded that patients from ward L could not be transferred without the patient's consent. The protocol detailed each of the three ward's aim and objectives and the profile of the patients cared for.

Patient care documentation including: initial assessments, care plans and patient progress notes were recorded on the Trust's PARIS patient information system. Records reviewed by the inspector were noted to be individualised to each patient, comprehensive and up to date. Patient signatures, or an explanation for the absence of a signature, were recorded as required. The inspector was informed that the Trust's PARIS system was continuing to be developed. Further changes to support greater access and recording of all patient records, including medical records, onto the system would be introduced in the near future.

Staff who met with the inspector explained that they felt the ward had implemented a number of significant changes during the previous eight months. The changes included: clearer patient admission and discharge protocols; increased availability of psychological services to patients; the completion and updating of nurse mandatory training; the completion of staff supervision and appraisal as required and the introduction of a uniform policy for managing patients' finances within the ward. Staff informed the inspector that they felt the changes had been positive.

4.1 Implementation of Recommendations

Three recommendations which relate to the key question "**Is Care Safe**?" were made following the inspection undertaken on 5 and 6 August 2014.

These recommendations concerned multi-disciplinary team meetings, trust guidance regarding the care of young people age less than 18 years who may be admitted to the ward and staff training.

The inspector was pleased to note that all three recommendations had been fully implemented:

- The multi-disciplinary team were reviewing and discussing all incidents;
- The trust had updated guidance regarding the admission protocol for young people;
- Staff had completed up to date mandatory training.

Eight recommendations which relate to the key question "**Is Care Effective**?" were made following the inspection undertaken on 5 and 6 August 2014.

These recommendations concerned team meetings, the trust's finance procedures, psychological interventions, the transfer of patients, the ethos of Ward L, patient involvement in planning their care and treatment and nursing supervision.

The inspector was pleased to note that all eight recommendations had been fully implemented:

- Ward staff team meetings were being held on a regular basis;
- A uniform policy for managing patient finances was available and up to date;
- Psychological services were available to all patients o the ward;
- Protocols and procedures regarding the transfer of patients from the ward had been introduced;
- Information regarding the ward's purpose, aim and objectives was available;
- Admission criteria had been developed and made available to all staff;
- Patients had signed their care records;
- Nursing staff had received their supervision and appraisal in accordance to professional and trust standards.

One recommendation which related to the key question "**Is Care Compassionate**?" was made following the inspection undertaken on 5 and 6 August 2014.

This recommendation concerned the transfer of patients from ward L. The inspector was pleased to note that the recommendation had been fully implemented. Patients were not transferred from the ward without their consent and with the agreement of the multi-disciplinary team.

5.0 Ward Environment

"A physical environment that is fit for purpose delivering a relaxed, comfortable, safe and predictable environment is essential to patient recovery and can be fostered through physical surroundings." Do the right thing: How to judge a good ward. (Ten standards for adult-in-patient mental health care RCPHYSH June 2011)

The inspector assessed the ward's physical environment.

Summary

Ward L is located on the third floor of an old Victorian building. Space within the ward is limited and patients are required to travel down one flight of stairs to access the ward's courtyard.

The inspector reviewed the court yard and noted that it was untidy and required cleaning. The yard was littered with smoking debris and the walls were dirty and covered in graffiti. A recommendation has been made.

During the inspection the inspector noted that staffing levels were appropriate to the assessed needs of the patients. Despite the limitations of space the main ward areas were clean and clutter free. The ward was in the process of being redecorated and it was positive to note that patients and staff had been consulted regarding colour schemes. The ward's bed areas had been well maintained and the bathrooms were clean and odour free.

The inspector noted that there were ten profiling beds on ward L. In December 2013 the Health and Social Care Board requested that all HSC Trusts take appropriate actions in accordance with the Northern Ireland Adverse Incident Centre Estates and Facilities Alert EFA/2010/006. The alert was distributed as a result of a fatality. The profiling beds on Ward L present the same level of risk associated with ligature points as was the case when the fatality occurred.

It was good to note that the ward manager was reviewing the ward's risk management processes and the use of profiling beds. However, a clear risk management strategy regarding the use of ten profiling beds, four of which were located in single rooms, was not available. A recommendation has been made.

5.1 Observation Session

Communication and behaviour is a vitally important component of dignified care. The Quality of Interaction Schedule (QUIS) is a method of systematically observing and recording interactions whilst remaining a non-participant. It aims to help evaluate the type of communication and the quality of communication that takes place on the ward between patients, staff, and visitors.

The inspector completed direct observations using the QUIS tool during the inspection and assessed whether the quality of the interaction and communication was positive, basic, neutral, or negative.

Positive - care and interaction over and beyond the basic care task demonstrating patient centred empathy, support, explanation and socialisation.

Basic – care task carried out adequately but without elements of psychological support. It is the conversation necessary to get the job done.

Neutral – brief indifferent interactions

Negative – communication which is disregarding the patient's dignity and respect.

5.2 Summary

The formal session involved observation of interactions between staff and patients/visitors. Four interactions were noted. The outcomes of these interactions were as follows:

Positive	Basic	Neutral	Negative
75%	25%	0%	0%

The inspector's observations of interactions between staff and patients noted positive communication and relationships between patients and staff. The inspector evidenced that staff were empathetic, reassuring and supportive. Staff were available throughout the ward and actively engaged patients in conversation.

Patients presented as relaxed and at ease in their surroundings. The inspector noted that requests from patients to staff were dealt with promptly and appropriately. During the interactions observed by the inspector, patients were treated with respect and staff demonstrated genuine interest regarding patient concerns and presentation.

The detailed findings from the observation session are included in Appendix 2

6.0 Patient Experience Interviews

Two patients agreed to meet with the inspector to talk about their care, treatment and experience as a patient. Both patients agreed to complete a questionnaire.

Patients who met with the inspector stated that they knew why they were in hospital and understood the purpose of the ward and the reason why they had been admitted. Both patients stated they had been given the opportunity to be involved in their care and treatment. Patients reported that they had also been able to involve their families.

Patients explained that they knew what an advocacy service was and they understood the role of the advocate. It was positive to note that patients felt safe on the ward. Both patients reported positively regarding the care and support they received from staff. Patient's comments included:

"Staff are good at listening and make time for you"; and

"Staff are excellent".

Both patients detailed that items had been removed from them. The items removed had included their razors. Patients relayed that staff had explained the reasons why their razors had been removed. Patients reported no difficulties in accessing their personal items as required.

Patients who met with the inspector detailed that they would know who to talk to if they had a concern or something was making them unhappy. Each patient reported that they were satisfied with the quality of the care and treatment they had received during their admission.

7.0 Other areas examined

During the course of the inspection the inspector met with:

Ward Staff	7
Other ward professionals	0
Advocates	1

Ward staff told the inspector that there had been positive changes on the ward during the previous eight months. Staff were complimentary regarding the support they received from the multi-disciplinary team, colleagues and managers. The multi-disciplinary team was reported to be effective and staff felt that colleagues from other disciplines considered their professional views and opinions. A student nurse reflected positively on their initial induction to the ward and on the support they had received from their mentor and the ward staff team. Ward staff comments included:

"Ward's brilliant";

"Patient movement between the wards is now more controlled";

"The staff reflective practice group and the staff interpersonal dynamics formulation group are really useful";

"I had an excellent induction. This is a great place to work and has been great for my confidence";

"The ward has a good multi-disciplinary team with positive integration between all staff";

"I feel involved and listened to";

"The multi-disciplinary team is encouraging and supportive. I feel I am listened to and that my opinion is considered";

"There's a real sense of team".

The advocate told the inspector that the advocacy service provided a patient clinic on the ward every Tuesday afternoon. During the clinic the advocate completed a tour of the ward and introduced themselves to each patient.

Patients were given the opportunity to discuss the role and purpose of the advocacy service. The advocate also enquired as to any support or assistance a patient may need. The advocate reported no concerns regarding their experience of the ward. The advocate's comments included:

"Ward L staff are good, supportive and helpful".

8.0 Next Steps

A Quality Improvement Plan (QIP) which details the areas identified for improvement has been sent to the ward. The Trust, in conjunction with ward staff, must complete the QIP detailing the actions to be taken to address the areas identified and return the QIP to RQIA by 9 June 2015.

The lead inspector will review the QIP. When the lead inspector is satisfied with actions detailed in the QIP it will be published alongside the inspection report on the RQIA website.

The progress made by the ward in implementing the agreed actions will be evaluated at a future inspection.

Appendix 1 – Follow up on Previous Recommendations

Appendix 2 – QUIS
(This document can be made available on request)

Inspection findings

Follow-up on recommendations made following the unannounced inspection on 5 and 6 August 2014

No.	Reference.	Recommendations	No of times stated	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	5.3.1(a)	It is recommended that the Ward Manager ensures that the minutes of multi-disciplinary meetings reflect discussion and analysis of incidents.	2	The inspector reviewed the minutes of multi-disciplinary team meetings(MDT). The MDT met on a weekly basis to complete a review of each patient's care, treatment and progress. The inspector reviewed three sets of patient care records. Records evidenced that each patient's progress continued to be monitored by the MDT. MDT minutes recorded developments in relation to the patient's treatment and care pathway, presenting risks to the patient, use of restrictive practice and involvement in therapeutic activity. The MDT minutes also reported on any other issues or concerns to include any incidents the patient may have been involved in. A ward governance meeting was convened each month to discuss incidents on the ward. The meeting was attended by the Ward Manager, ward staff, the Trust's senior mental health nurse, the nurse development lead and the ward's operation manager. The inspector reviewed the minutes from a governance meeting which had taken place on the 10 March 2015. The minutes evidenced that staff reviewed the incidents that had taken place on the ward during the previous month. Incidents were discussed and analysed and any actions required to minimise similar incidents occurring in the future had been agreed and implemented.	**Fully met**

2	5.3.1(c)	It is recommended that Trust guidance regarding the admission protocol for young people in the care of the child and adolescent mental health services is reviewed and updated and is made available to all staff.	2	The Trust's '*Admission Protocol for Young People in the Care of the Child and Adolescent Mental Health Services who are admitted to Acute Adult Mental Health Wards'* had been updated. The policy had been approved on the 19 August 2014 and was due to be reviewed on the 19 August 2017. A copy of the protocol was available in the ward's main office and on the Trust's intranet. The inspector was informed that each member of the ward team could access the intranet as required.	**Fully met**
3	5.3.3(d)	It is recommended that team meetings for ward staff are held on a regular basis.	2	The inspector reviewed the ward's arrangements regarding staff team meetings. Meetings were held on a monthly basis and minutes from previous meetings reviewed by the inspector were noted to be comprehensive and up to date. Staff who met with the inspector reported no concerns regarding their ability to access regular team meetings.	**Fully met**
4	4.3(f)	It is recommended that the Trust introduce a uniform policy for managing patients' finances across all wards	2	The Trust's *'Patients' Finances and Private Property-Policy for Inpatients within Mental Health and Learning Disability Hospitals'* was up to date and had been implemented in September 2014. A copy of the policy was available in the ward's main office and on the Trust's intranet. A staff declaration sheet evidenced that staff had read and understood the procedures concerning the management of patient's private property.	**Fully met**
5	5.3.3(d)	It is recommended that the Trust ensures that psychological services are available to patients on the ward.	2	The inspector met with eight members of the wards multi-disciplinary team included the psychologist. Staff informed the inspector that patients on ward L could access psychological assessment and intervention as required and within two working days of being referred. Patients could access one to one psychological interventions and	**Fully met**

				groupwork. One to one interventions included: psychological assessment for conditons/illnesses such as dementia, cognitive functioning and IQ. Having completed an assessment patients could then access a treatment relevant to their needs. This included cognitive behavioural therapy (CBT) and interventions relative to the management of depression, stress, trauma, grief, paranoia, and agoraphobia. Patients could also access therapeutic groups. These included relaxation, recovery, substance misuse management, self harm and self esteem groups. Groups were facilitated by a group therapist and the ward's occupational therapist.	
6	5.3.3(b)	It is recommended that the Trust ensures that patients admitted to ward Lard L are not transferred from the ward without the patient's consent and the agreement of the multi-disciplinary team.	1	In Decemebr 2014 the Trust introduced a protocol for the transfer of patients within acute mental health services. Section 4.6.2 in the protocol states *'Any decision to transfer a patient must be done on the basis of clinical need and with the consent of the patient'.* The inspector met with three patients. None of the patients reported any concerns about being moved from the ward. One patient reported that they had been asked if they would consider moving. The patient explained that they had refused and their decision had been respected. Staff who met with the inspector reported that patients were not moved without their consent. It was good to note that section 4.5 of the protocol stated that *'Patients who are unable to consent due to lack of capacity will not be transferred to another ward to facilitate another admission'.*	**Fully met**
7	6.3.1(a)	It is recommended that the Trust ensures that guidance regarding the internal transfer arrangements of patients and the criteria of admission to each	1	Section 4.0 (Key Guidance Principles) of the Trust's *'Protocol for the Transfer of Patients within Acute Mental Health Services in the Belfast Trust'* provided guidance regarding the transfer and admission arrangements for patients within each of the three wards.	**Fully met**

		of the three wards within the facility is developed and implemented and made available to all staff.			
8	6.3.1(a)	It is recommended that the Trust ensures that guidance regarding the purpose of ward L including the profile of the patients and the ward's aim and objectives is developed and made available to all staff.	1	The ward's main notice board located at the entrance to the ward provided a range of information regarding the ward. This included information detailing the ward's ethos and purpose. A large poster also recorded that the ward the provides specialist care for people over the age of 65. The inspector noted that the Trust's transfer protocol recorded that ward L- is a mixed gender acute mental health ward providing 14 beds, the ward specialises in treating and caring for patients over 65 with functional mental illness but will also treat and care for patients under 65. The protocol helped to ensure that staff remained aware of ward L's admission criteria. Nursing staff who met with the inspector reported that they understood the purpose and function of the ward and the profile of the patients. Staff informed the inspector that the Trust's protocol had been helpful in assuring that patients over 65 were appropriately cared for within ward L.	**Fully met**
9	6.3.1(d)	It is recommended that the Trust ensures that guidance regarding the criteria for admission to ward L is developed and made available to all staff.	1	Sections 1.1 and 4.0 to 4.6 of the Trust's protocol for the transfer of patients within acute mental health services, provided guidance regarding the criteria for admission to ward L. A copy of the protocol was available in the ward's main office and on the Trust's intranet. Information regarding the ward's ethos and purpose was posted on the ward's main notice board located opposite the ward's main entrance.	**Fully met**
10	6.3.2(b)	It is recommended that the	1	The inspector reviewed three sets of patient care documentation.	**Fully met**

		Ward Manager ensures that all patient care documentation is completed in accordance with the required standard. The Ward Manager should also ensure that patient signatures (or explanation for the absence of patient signature) are recorded where required.		Patient care plans, consent forms and multi-disciplinary team meeting records contained patients' signatures or an explanation as to why a signature was not available. The inspector noted one signature was not available on a patient's risk assessment. An explanation as to why the patient had not signed the assessment was available. The ward's operational manager and the Ward Manager had introduced a patient care record audit tool. The tool included audits of all multi-disciplinary records. The inspector was informed that four patient files were audited each month. The inspector reviewed eight audit records completed between February and April 2015. The records evidenced that files had been audited appropriately and patient assessments, care plans and risk assessments had been scrutinised. The inspector noted that where a patient signature was not recorded this was discussed with the staff member who had completed the record with the patient. The record was then discussed with the patient and the patient's signature was sought.	
11	5.3.3(d)	It is recommended that the Trust and the Ward Manager ensures that all staff working on the ward complete their mandatory training as required by the Trust.	1	The ward's nurse training record matrix evidenced that all staff had completed the required up to mandatory training in relation to child protection, safeguarding vulnerable adults, the use of physical intervention, infection control and life support training. It was positive to note that nursing staff training requirements were being monitored weekly. Staff requiring refresher training were identified and booked to complete training at the nearest opportunity.	**Fully met**
12	5.3.3(d)	It is recommended that the Ward Manager ensures that all nursing staff receive	1	The inspector reviewed the ward's nursing staff supervision and appraisal records. The records evidenced that all staff had received two supervison sessions and their appraisal during the	**Fully met**

		supervision in accordance to Trust and professional standards and guidelines.		previous 12 months. The inspector was informed that all nursing staff were offered a supervision session on a quarterly basis. Nursing staff who met with the inspector reported no concerns regarding their ability to access one to one supervision and appraisal.	

Quality Improvement Plan

Unannounced Inspection

Ward L, Mater Hospital

17 April 2015

The areas where the service needs to improve, as identified during this inspection visit, are detailed in the inspection report and Quality Improvement Plan.

The specific actions set out in the Quality Improvement Plan were discussed with the charge nurse, the operations manager, the nurse manager, the quality and information manager and ward staff on the day of the inspection visit.

It is the responsibility of the Trust to ensure that all requirements and recommendations contained within the Quality Improvement Plan are addressed within the specified timescales.

Recommendations are made in accordance with The Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS, 2006.

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
Is Care Safe?					
1	Section 5.3.1 (f)	It is recommended that the ward manager ensures that when a patient is assessed as requiring a profiling bed a risk assessment is completed in accordance to Northern Ireland Adverse Incident Centre (NIAC) Estates Facilities Alert /2010/006. A ward environmental risk assessment in relation to the use of profiling beds should also be completed.	1	Immediate and ongoing	Following a review in conjunction with the Operations Manager, the number of profiling beds within Ward L has been reduced from 10 to 7. A generic risk assessment has been devised in relation to profiling beds on the ward and any patient using a profiling bed will have a care plan in relation to this.
2	Section 7.3 (H)	It is recommended that the ward manager ensures that the outside courtyard area used by patients from ward L is properly maintained. This should include the removal of smoking debris and repainting of the court yard walls.	1	Immediate and ongoing	A Quality Circle meeting has taken place. Staff from Ward L, PCSS and Estates Services were in attendance. It has been agreed that smoking shelters will be removed from the Mater Hospital Psychiatric Department. The patients were informed of this decision and have raised no objections. This will be completed within one month. Liaison is ongoing with PCSS and Estates

Recommendations are made in accordance with The Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS, 2006.

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
					Services Managers regarding the routine removal of smoking debris and regarding the repainting of the court yard walls.
Is Care Effective?					
		No recommendations made			
Is Care Compassionate?					
		No recommendations made			

Recommendations are made in accordance with The Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS, 2006.

NAME OF WARD MANAGER COMPLETING QIP	Jonathan Killough
NAME OF CHIEF EXECUTIVE / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Martin Dillon, Deputy Chief Executive

Inspector assessment of returned QIP				**Inspector**	**Date**
		Yes	**No**		
A.	Quality Improvement Plan response assessed by inspector as acceptable	x		Alan Guthrie	5 June 2015
B.	Further information requested from provider				