Unannounced Follow Up Inspection Report
14-15 June 2017

Ward L
Acute Mental Health
Mater Hospital
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Belfast
BT14 6AB

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Inspector: Cairn Magill

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Assurance, Challenge and Improvement in Health and Social Care

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service provider from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

Ward L is a 14 bedded acute psychiatric inpatient facility. It is one of three psychiatric inpatient units located within the Mater Hospital site. Ward L is a mixed gender ward providing care and treatment to patients over 65 years. The ward also provides care and treatment to patients, from age 18, admitted 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 and support staff. It is situated on the third floor of the psychiatric department and provides a combination of single rooms and dormitory accommodation.

On the days of inspection there were 14 patients admitted to the ward. Five patients were admitted in accordance with the Mental Health (Northern Ireland) Order 1986.

3.0 Service details

Responsible person: Martin Dillon	**Ward Manager:** Jonathan Killough / Eileen Stevenson
Category of care: Acute Mental Health Inpatient	**Number of beds:** 14
Person in charge at the time of inspection: Jonathan Killough / Eileen Stevenson	

4.0 Inspection summary

An unannounced follow-up inspection took place over two days on 14 and 15 June 2017.

The inspection sought to assess progress with findings for improvement raised from the most recent previous unannounced inspection on 26-30 October 2015. This inspection also assessed if Ward L was well led.

Evidence of good practice was found in relation to a number of quality improvement initiatives which staff were continuing to work on. There was good planning around ensuring adequate medical cover was provided during the evenings and weekends and there were good working relationships within the multidisciplinary team. Staff had an opportunity to attend the monthly governance meetings which reviewed accidents and incidents and learning gained from significant event audits was shared on the learning board in the main office.

Areas requiring improvement were found in relation to ward cleanliness and the lack of a consistent approach to completing ligature risk assessments for patients using profiling beds. The pharmacy presence on the ward was irregular and there were no regular patient forum meetings or other means of obtaining patient or carer feedback. There were gaps in training for staff and a number of policies were out of date. Staff had not followed appropriate procedures in relation to an adult safeguard referral.

During the inspection the inspector noted that one of the bathrooms used for male patients was not clean.

Views of patients:

The inspector spoke to five patients, four of whom completed the patient experience questionnaire. All five patients confirmed they were happy about their care and treatment and stated they felt safe on the ward and had no concerns. In general, patients stated they were happy about therapeutic and recreational activities on offer during the week. However some patients reported a lack of activities occurring at the weekends. This issue was discussed with staff. Weekend activities on the ward are dependent upon the nursing needs of the ward and staffing levels. Whenever possible, staff accommodate activities during the weekend. Patients made the following comments;

“The care here is first class, they couldn’t be any more caring, kind and understanding.”

“It’s a relaxed atmosphere here. Staff joke with you and you are made to feel comfortable.”

“They go out of their way to be helpful.”

“There is not much to do on Sundays. The day is long.”

“Staff are always helping. They helped me understand the directions on a clothes label. It’s the little things they do mean so much.”

“Staff are very kind and caring. If you need help they are only too willing to help.”

“There is quite a high standard of care here.”

“It’s hard to think of something they could improve on here.”

“Occasionally I have a chat with the nurses and they answer in a very helpful way. They are pretty straight with me but I appreciate that.”

“They are very precise and punctual if anybody presses the button they are there in two seconds.”

“This is the best place to go to get help. Staff are one hundred percent, they take the time to listen and they know what to say to make you feel better.”

“It was the best thing that ever happened to me, was to come in here. If you need help it’s the best place to be.”

“If anything was to improve it would be all side rooms for the men.”

Relatives views

The inspector met with two relatives, one of whom completed the relative’s questionnaire. Both relatives confirmed they were kept informed and updated on the progress of their family

member and they stated all staff on the ward treated their family members with respect and upheld their dignity. Relatives made the following comments;

“Staff are awfully good.”

“The staff have great patience.”

“I have seen staff with other patients and they are kind and good. Compared to ordinary hospital staff here, they go that bit extra. They go out of their way for patients.”

“The communication here is very, very good. They are such nice staff. I can talk to whoever is there. Staff immediately approach me and keep me updated. They are very good.”

“They respect X’s privacy and dignity”

Staffs view

The inspector met with one visiting professional, the service manager and 11 members of the multidisciplinary team, four of whom completed the staff questionnaire. Ward based staff confirmed they receive regular supervision and stated they were supported in their role. All staff stated they had no issues of concern in respect of the care delivered to patients or the ward in general and confirmed they enjoyed working on the ward. Staff made the following comments;

“There is good team work, good communication and you can seek clarification on any matter.”

“My induction was very thorough, in fact incredibly so. There were power point presentations, I was orientated around the ward and shown how the bleeper system works and introduced to all staff.”

“The other staff are great. They take you under their wing and volunteer to look after you. I feel very supported.”

“I feel safe. The patients are safe. I have no concerns.”

“The occupational therapists are fantastic at engaging patients here. The feedback I am getting is patients feel good and enjoy the mix of activities getting out and about.”

“There are plenty of staff on the floor. There is definitely a better nursing presence on the ward and patients feel they can approach nurses and have a chat with them.”

“It’s quite a friendly nice ward. Very calm”

“Honestly X just respects staff. Everyone knows what they are doing and everything tends to flow.”

“The multidisciplinary relationships are good here. I am very happy here.”

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	Eight

There are eight areas for improvement, one of which has been restated for a second time as it has not been met and seven new areas for improvement have been made. These have been included 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 (MDT), 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.

The following areas were examined during the inspection:

- Ward environment.
- Activity schedule.
- Learning Board for sharing best practice.
- Policies and procedures.
- Training matrix.
- Minutes of staff and governance meetings.
- Incident records.
- Complaints and compliments log.
- Falls audit.
- Pathway for medical cover during evenings and weekends.
- Duty rota.

We reviewed the one area for improvement made at the previous inspection and an assessment of compliance was recorded as not met.

6.0 Review of areas for improvement from the last unannounced inspection 26- 30 October 2015

The most recent inspection of Ward L was an unannounced inspection. The completed PCP was returned and approved by the responsible inspector. This PCP was validated by inspectors during this inspection.

Areas for Improvement from last inspection		Validation of Compliance
Area for improvement 1 **Ref**: standard 5.3.1 (f) **Stated:** First Time	The Trust's environmental cleanliness and mental health services admission and discharge policies required review.	**Not met**
	Action taken as confirmed during the inspection: The Trust's Adult Mental Health Acute Inpatient Admission Wards Operational Policy was in draft form and had not been signed off. The Trust's environmental cleanliness policy had not been updated. This area for improvement will be restated for the second time.	

6.1 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

There was a defined organisational and management structure in place. Staff who spoke to the inspector were aware of this structure and of the recent changes to the newly appointed acting ward manager and acting deputy ward manager.

Staff who spoke to the inspector stated they enjoyed working on the ward and stated they were well supported by their colleagues and the ward manager.

There were appropriate systems in place to record and report incidents, accidents and serious adverse incidents. There was evidence that learning from incidents was cascaded down to ward staff via the shared learning board and minutes of team meetings.

Ward staff had the opportunity to attend the monthly governance meetings.

Staff shortages were appropriately managed and continually reviewed.

Staff reported good working relationships between members of the MDT.

Staff from the MDT who met with the inspector confirmed they had up to date appraisals in place and received supervision in accordance with their professional guidance.

It was good to note that staff were involved in a number of Safety Quality Belfast Programmes such as:

- The Feel Good Programme for staff morale. This project monitored staff morale to assess, improve and promote good mental health in the work environment.

- The Fall Safe Project. The project's focus was to monitor and audit falls on the ward with the aim of reducing falls.

The Trust took appropriate measures to ensure access to medical cover was available during evenings and weekends when the mental health duty doctor was covering cases in another inpatient facility across Belfast. A flowchart of how to contact a general acute hospital duty doctor is posted in the main office.

Monthly reflective practice sessions for the multidisciplinary team are facilitated by a member of the clinical psychology team.

A specialised nurse practitioner with a background in self-harm and personality disorder facilitates a further reflective practice session fortnightly.

Areas for improvement

The ligature risk assessment for patients using a profiling bed was not completed in all cases.

The names and designation of those in attendance at the monthly governance meeting were not recorded in the minutes.

Patient forum meetings were not occurring regularly and staff were not recording when they were offered to patients or when patients decline the opportunity to attend.

There were a number of staff who required updated mandatory training as per Trust training matrix.

The male shower/toilet area was not thoroughly cleaned.

Staff had not followed appropriate procedures in relation to an adult safeguard referral.

Pharmacy support on the ward was inconsistent.

7.0 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.

7.1 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 RQIA for assessment by the inspector by 10 August 2017.

Provider Compliance Plan	
The responsible person must ensure the following findings are addressed:	
Area for Improvement No. 1 **Ref:** Standard 5.3.1 (a) **Stated:** First Time **To be completed by** 15 August 2017	The ligature risk assessment for patients using profiling beds was not completed in all cases.
	Response by responsible individual detailing the actions taken: Ligature risk assessments for any patient using a profiling bed have been reviewed and updated.
Area for Improvement No. 2 **Ref:** Standard 5.3.1 (f) **Stated:** First Time **To be completed by**: 15 August 2017	The names and designation of those in attendance at the monthly governance meeting are not recorded in the minutes.
	Response by responsible individual detailing the actions taken: The names and designation of those in attendance at the monthly governance meeting are now captured in the minutes.
Area for Improvement No. 3 **Ref:** Standard 6.3.2 (g) **Stated:** First Time **To be completed by:** 15 August 2017	Patient forum meetings were not occurring regularly and staff were not recording when they were offered to patients or when patients decline the opportunity to attend.
	Response by responsible individual detailing the actions taken: This issue has now been addressed in Ward L; a member of staff has been allocated to ensure that patient forum meetings take place or to document the reason that these did not take place. The Operations Manager for Acute Mental Health Inpatient Services will raise this as an agenda item at his next acute mental health services meeting.
Area for Improvement No. 4 **Ref:** Standard 4.3 (m) **Stated:** First Time	There was a number of staff who required updated mandatory training as per Trust training matrix.
	Response by responsible individual detailing the actions taken: The ward continues to work towards full compliance with its

To be completed by: 15 December 2017	statutory/mandatory training in conjunction with the Senior Professional Nurse. Training will be accessed via e-learning, courses routinely available through the Trust/CEC or bespoke training will be arranged.
Area for Improvement No. 5 **Ref:** Standard 5.3.1 (f) **Stated:** First Time **To be completed by:** 15 August 2017	The male shower/toilet area was not thoroughly cleaned.
	Response by responsible individual detailing the actions taken: This issue has now been addressed. Work schedules for PCSS staff have also been revised and amended to ensure that the male shower/toilet area is thoroughly cleaned. PCSS Managers continue to complete an environmental cleanliness audit of each ward on a monthly basis; showering/toilet areas are reviewed as part of this audit. The Ward Manager will also monitor the condition of the ward including male shower/toilet area on a daily basis.
Area for Improvement No. 6 **Ref:** Standard 5.3.1(c) **Stated:** First Time **To be completed by:** 15 August 2017	Staff had not followed correct procedures for an adult safe guarding referral.
	Response by responsible individual detailing the actions taken: This situation was not straight forward and had involved advice from the Department of Legal Services. An effective protection plan was in place for some time before the inspection however the Trust accepts that an Adult safeguarding referral should have been made at the point the protection plan was put in place. An ASP1 referral was made following the recommendation from the Inspector at the time of inspection. Future adult safeguarding referrals will be made as per the Safeguarding Protocol.
Area for improvement No. 7 **Ref**: 5.3.1(f) **Stated:** Second Time **To be completed by:** 15 December 2017	The Trust's environmental cleanliness and mental health services admission and discharge policies required review.
	Response by responsible individual detailing the actions taken: The environmental cleanliness policy is currently being reviewed and updated by the Trust's Corporate Nursing Directorate. This policy should be in place within the inspector's timescales. Work continues on the admission and discharge policy for mental

	health services; this will be completed within RQIA's timescale.
Area for improvement No. 8 **Ref**: Standard 5.3.1 (f) **Stated:** First Time **To be completed by:** 15 September 2017	Pharmacy presence on the ward was inconsistent.
	Response by responsible individual detailing the actions taken: There is no funding for consistent pharmacy input across the wards. However there are good working relationships with colleagues in the Pharmacy Department. Staff are able to contact Pharmacy on an adhoc basis for advice. Pharmacy colleagues will also attend the ward including ward rounds on request.

Name of person (s) completing the PCP	Eileen Stevenson (Acting Ward Sister, Ward L), SallyAnn Slevin (Deputy Ward Sister, Ward L), Siobhan McKaigue (Deputy Ward Sister, Ward L), Johnny Killough (Ward Manager, Ward J), Paul Quinn (PCSS Manager), Cahal McKervey (Operations Manager), John Artt (Nurse Development Lead), Patricia Minnis (Quality and Information Manager		
Signature of person (s) completing the PCP		**Date completed**	30/07/2017
Name of responsible person approving the PCP	Martin Dillon		
Signature of responsible person approving the PCP		**Date approved**	04/08/2017
Name of RQIA inspector assessing response	Cairn Magill		
Signature of RQIA inspector assessing response		**Date approved**	14/08/2017

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