Unannounced Follow - Up Inspection Report
7 - 8 March 2018

Cranfield Ward 2
Mental Health Acute Inpatient Ward
Muckamore Abbey Hospital
1 Abbey Road
Muckamore
BT41 4SH

Tel No: 02895042063

Inspectors: Cairn Magill and Wendy McGregor
Lay Assessor: Alex Parkinson

www.rqia.org.uk

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

Cranfield Ward 2 is a 15 bedded ward with an additional apartment that provides care and treatment to male patients with a learning disability who have an enduring mental illness and complex behaviours that challenge. On the days of the inspection there were 15 patients on the ward and one patient in the apartment. Two patients were detained in accordance with the Mental Health (Northern Ireland) Order 1986. Fourteen patients were delayed in their discharge.

3.0 Service details

Responsible person: Michael McBride	**Ward Manager: Linda Macartney**
Category of care: Acute Mental Health	**Number of beds: 16**
Person in charge at the time of inspection: Linda Macartney	

4.0 Inspection summary

An unannounced follow-up inspection took place over two days on 7-8 March 2018.

The inspection sought to assess progress with the findings for improvement raised from the most recent previous unannounced inspection 28 – 30 November 2016.

Of the five areas of improvement that were noted at the previous unannounced inspection, four were met and one was partially met. Improvement was noted with regard to completion of;

- promoting quality care (PQC)
- risk assessments,
- financial risk assessments,
- review of dysphasia assessments and
- the involvement of consultant psychiatrists and medical staff in discharge planning meetings.

Some progress was noted in the writing of care plans to ensure they could be measured. Whilst this was good to note inspectors found that this approach was inconsistent. This area for improvement has been assessed as partially met.

Inspectors observed patient and staff interaction during the inspection. On the first day of inspection the ward was busy with members of the multi-disciplinary team such as physiotherapists visiting patients on the ward. Inspectors observed patients were offered a

choice for their breakfasts and the inspector observed a friendly relaxed interaction between patients and staff. It was good to note patients had access to day care on a daily basis.

A lay assessor accompanied the inspectors on inspection. The lay assessor met with three patients. Patients stated that they felt safe on the ward and that staff were sometimes busy, there were new named nurses allocated which patients were getting to know and sometimes the days were very long as there wasn't much to do on the ward during the day, evenings or weekends. Patients stated they could attend their meetings and ask any questions about their care.

Patients said,

"Yes (being in here) has helped me."

"Day care is not for me. It is very stressful being in the ward. They are very long days."

"I am looking out to the community to get my own place and get my life back to normal."

"I got a new named nurse and I am getting to know her."

"Staffing is a big issue."

"I feel upset sometimes because the whole process (discharge) takes too long."

Relatives said;

There were no relatives available during the inspection.

Staff said;

Inspectors met with five staff.

All staff who met with inspectors reported that they were satisfied that care on the ward was compassionate, effective and well-led.

Staff said that there were times were staffing levels were reduced. RQIA recognise that this is an ongoing issue on the Muckamore site and are aware that the Trust continues to actively recruit staff. A member of staff informed inspectors they were involved in an incident of verbal abuse with regard to their culture. The incident was recorded in accordance with Zero Tolerance from Abuse policy and procedures. However the nurse reported they did not receive individual support post incident. This scenario was discussed at feedback with senior members of the Trust. Senior managers of the Trust agreed to review their policy of offering individualised support to staff post incident and in particular with regard to culturally motivated verbal abuse.

All staff interviewed were knowledgeable on raising concerns in relation to patient safety, incidents and safeguarding vulnerable adults.

Staff comments include;

"With our safe numbers things are just manageable."

"This is a great staff team."

"We know the patients very well."

"We have supervision. It is good to have the ward manager back."

"Non-mandatory training has been cancelled due to staffing levels."

"I wouldn't be here if I didn't want to be here."

"I am here because I am needed."

"There is really constant communication."

"Patients have their own forum."

"We had our staff meeting last Wednesday."

"I could approach X if I needed to."

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	One

One area for improvement has been restated for a second time.

This is detailed in the Quality Improvement Plan (QIP).

Areas for improvement and details of the QIP were discussed with senior Trust representatives, members of the multi-disciplinary team, the ward manager and ward staff as part of the inspection process. The timescales for completion commenced from the date of inspection.

5.0 How we inspect

The inspection was underpinned by:

- The Mental Health (Northern Ireland) Order 1986.
- The Quality Standards for Health & Social Care: Supporting Good Governance and Best Practice in the HPSS, 2006.
- The Human Rights Act 1998.
- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.
- Optional Protocol to the Convention Against Torture (OPCAT) 2002.

The following areas were examined during the inspection:

- Care documentation in relation to four patients.
- Risk assessments in relation to three patients.
- Financial capacity assessments in relation to four patients.
- Ward environment.
- Minutes of Community and Hospital discharge planning meetings.

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

We reviewed the areas for improvements made at the previous inspections and an assessment of compliance was recorded as met/partially met.

6.0 The inspection

6.1 Review of areas for improvement from the last unannounced inspection 28 – 30 November 2016

The most recent inspection of Cranfield Ward 2 was an unannounced inspection. The completed QIP was returned and approved by the responsible inspector. This QIP was validated by inspectors during this inspection.

Areas for Improvement from last inspection		Validation of Compliance
Area for improvement 1 **Ref**: 5.3.1(a) **Stated: First Time**	One patient who had a history of choking had a nursing care plan in place which included guidance from speech and language therapy (SALT). However the patient had not been reviewed by SALT since August 2015. This was addressed with the deputy ward manager during the inspection and an appointment was arranged for SALT to review the patient on Friday 2 December 2016.	**Met**
	Action taken as confirmed during the inspection: The ward manager identified the patient who had a history of choking. The inspectors reviewed the patient's care documentation. Care documentation evidenced that the patient had received a review of their (dysphagia) swallow assessment in December 2016. A further review was completed in August 2017 following an incident when the patient	

	choked. It was noted that the care plan in relation to the patient's dysphagia assessment was reviewed and updated following this incident. The patient had a further review two weeks following the incident. The inspectors assessed this area of improvement as being met in accordance with the Dysphagia management guidance.	
Area for improvement 2 **Ref**: 5.3.1(a) **Stated: First Time**	Each comprehensive risk assessment and management plan was reviewed in accordance with PQC guidance. The information recorded in the review documentation was comprehensive and relevant however the review did not always reflect if the risk had reduced; remained the same or increased. **Action taken as confirmed during the inspection**: Inspectors reviewed comprehensive risk assessments, risk management plans and reviews in relation to three patients. Inspectors noted that reviews reflected if the risk had reduced; remained the same or increased.	**Met**
Area for improvement 3 **Ref**: 5.3.1(a) **Stated: First Time**	One patient did not have their financial capacity assessment completed in full. Although it was recorded that the patient was assessed as incapable with managing their finances, the scores were not completed to confirm the rationale for this decision. **Action taken as confirmed during the inspection**: The inspectors reviewed four sets of patient's financial capacity assessments. All four financial capacity assessments were completed in full. The scores were completed to confirm the rationale for the decision.	**Met**
Area for improvement 4 **Ref**: 6.3.1 **Stated: First Time**	14 out of 16 patients on the ward were assessed as ready for discharge. A number of patients on the ward were admitted due to a breakdown in their community placements. Patients expressed their frustration as their lives were more restricted than necessary. Of note patients who required admission for care and treatment had to wait for a bed to become available. Inspectors were informed that there was a lack of involvement of	**Met**

	consultant psychiatrists and ward nursing staff in the commissioning, planning and delivery of community placements. This applies to the hospital site. There were a lack of meetings between consultants and senior managers.	
	Action taken as confirmed during the inspection: Since the previous inspection the service manager coordinated monthly meetings for hospital and community staff to come together to discuss and plan complex discharges. Since then there were nine meetings. Medical representation was noted at all nine meetings with consultant psychiatrists at seven meetings. The minutes note those present which included, nursing staff, care managers, service and operation managers both from the community and the hospital staff. Issues discussed include; • Availability of placements. • The management structure of the facilities. • Staffing compliment and skill mix in the facilities. Identifying the challenges such as facility staff not reading care plans. • Policy development such as a policy to support outreach and in reach processes. • Reviewing resettlement progress Do any patients require restrictions and how these might be managed	
Area for improvement 5 **Ref**: 5.3.1(a) **Stated: First Time**	Goals were not consistently recorded in patient's care plans. It was noted that goals were documented as interventions and were not specific to the assessed need. For example it was documented that one patient's mode fluctuates and the goal was to promote positive mental health. This would have made the effectiveness of this care plan difficult to measure.	**Partially met**
	Action taken as confirmed during the inspection: Inspectors reviewed care plans for five patients. There was evidence that some progress has been made to address this area for improvement. However there was evidence of an inconsistent approach to recording goals that were specific and measurable. This area for improvement has been assessed as partially and will be restated for a second time.	

7.0 Provider Compliance Plan

Areas for improvement identified during this inspection are detailed in the Quality Improvement Plan (QIP). Details of the QIP were discussed with senior Trust representatives, members of the multi-disciplinary team, ward manager, and ward staff as part of the inspection process. The timescales commence from the date of inspection.

The responsible person must ensure that all areas for improvement identified within the QIP 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 quality improvement 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 quality improvement plan via the web portal for assessment by the inspector by 3 May 2018**.**

Quality Improvement Plan	
The responsible person must ensure the following findings are addressed:	
Area for Improvement No. 1 **Ref:** 5.3.1(a) **Stated:** Second Time **To be completed by 7 June 2018**	Goals were not consistently recorded in patient's care plans. It was noted that goals were documented as interventions and were not specific to the assessed need. For example it was documented that one patient's mood fluctuates and the goal was to promote positive mental health. This would have made the effectiveness of this care plan difficult to measure. **Response by responsible individual detailing the actions taken:** In response to this area of improvement, the ward manager will ensure all registrants attend training in relation to care planning, a section of this training focuses on goal setting.

Name of person (s) completing the QIP	Linda Macartney		
Signature of person (s) completing the QIP	Linda Macartney	**Date completed**	April 2018
Name of responsible person approving the QIP	Martin Dillon		
Signature of responsible person approving the QIP	Martin Dillon	**Date approved**	April 18
Name of RQIA inspector assessing response	Cairn Magill		
Signature of RQIA inspector assessing response		**Date approved**	3/05/2018

Please ensure this document is completed in full and returned to RQIA via the Web Portal

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