Unannounced Inspection Report
22 November 2018

Cranfield Ward 1
Muckamore Abbey Hospital
1 Abbey Road
Muckamore
Co. Antrim
BT41 4SH

Tel No: 02895 042058

Inspectors: Wendy McGregor and Alan Guthrie

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

Cranfield ward 1 is a twelve bedded ward on the Muckamore Abbey Hospital site. The purpose of the ward is to provide assessment and treatment to male patients with a learning disability who need to be supported in an acute psychiatric care environment. On the day of the inspection there were 12 patients admitted to the ward. Five patients were detained under the Mental Health (Northern Ireland) Order 1986. There were six patients on the ward whose discharge from hospital was delayed.

Patients within the ward receive support from a multidisciplinary team (MDT) which includes: psychiatry; nursing; clinical psychology, behavioural support and social work professionals. A patient advocacy service is also available.

3.0 Service details

Responsible person: Martin Dillon, Chief Executive Officer, Belfast Health and Social Care Trust	**Ward Manager:** Oisin McAuley (Acting ward manager)
Category of care: Learning Disability	**Number of beds:** 12
Person in charge at the time of inspection: Morning – Staff Nurse Bronagh Agnew Afternoon – Acting ward manager Oisin McAuley	

4.0 How We Inspect

To prioritise the areas we visit, we consider a range of factors including risk, quality and the context of the services.

These may include, for example, a ward:

- where previous inspections or our intelligence monitoring has flagged a concern or risk
- about which we have received a complaint, there has been a safeguarding alert or we have heard a disclosure from a whistle blower
- we have not inspected for a long period
- we have been made aware of areas of good practice
- a request has been made by the Department of Health, Health and Social Care Board or Public Health Agency
- which have been subject to serious adverse incident(s) and or media attention

We review a range of intelligence relevant to the service including: ward performance reports, use of Mental Health (NI) Order (1986) (MHO) legislation, quality indicators, quality improvement plans and ward and trust wide governance documents.

Each ward is assessed using an inspection framework. The inspection methods used include; discussion with patients and relatives, observation of practice; focus groups with staff and review of documentation. Records examined during the inspection include: nursing records, medical records, senior management and governance reports and minutes of meetings, staffing levels and rotas, performance reports and training records.

4.1 Inspection summary

An unannounced inspection took place on 22 November 2018.

The purpose of the inspection was to assess if the Trust's safeguarding procedures had been followed to support and help ensure the safety of a patient. The inspection was assessed as necessary following receipt of information, of a safeguarding nature, in respect of a specific patient being brought to our attention.

Inspectors visited the ward and reviewed the care and treatment and safeguarding processes in place for the patient. Inspectors evidenced the following outcomes:

Good practice

- There were comprehensive multi-disciplinary assessments in place for the patient. The assessments identified the patient's complex, physical and behavioural needs;
- Safeguarding processes were adhered to in every event that a concern was raised regarding the patient;
- A safeguarding vulnerable adult protection plan was in place;
- Communication between the ward staff and the patient's family was good.

Inspectors were concerned that

- The patient's discharge was delayed and they no longer required to remain in hospital;
- Coordination and oversight of the patient's care and treatment plans required improvement;
- Staff were not consistently recording aspects of the patient's physical health care such as their weight, elimination records and food and fluid records. We previously made an area for improvement regarding the management of patients' physical health care needs. The quality improvement plan (QIP) from the previous inspection was not reviewed as part of this inspection. However, inspectors were concerned that the management of patient's physical health care needs continued to be a concern. Subsequently, this area for improvement will be stated for a second time.

4.2 Inspection outcome

Following our inspection we provided feedback on our findings to the ward manager. This feedback, delivered by the lead inspector highlighted the areas of good practice and identified areas for improvement. The inspection considered the following areas specific to the patient's care and treatment.

Safeguarding arrangements for the Patient

Inspectors reviewed the safeguarding arrangements for the patient. Five safeguarding referrals had been made and these were at different stages of the safeguarding process. Inspectors reviewed safeguarding referrals that had been made recently and referrals that had progressed to investigation by a designated adult protection officer (DAPO). Inspectors noted no concerns in relation to the management and investigation of safeguarding referrals for this patient.

Allegations against staff were being investigated external to the Trust and in accordance with the regional adult safeguarding policy and procedure. The safeguarding lead for the Belfast Trust was co-ordinating and facilitating the investigations and reviews.

Protection plans for the patient were being implemented and recorded in the patient's care records. The protection plans detailed the following actions to help ensure the patient's safety and wellbeing:

- The patient was prescribed level 3 enhanced observations supported by two staff at all times. This was to ensure that should the patient make an allegation this is witnessed by two staff. The patient's continued need for enhanced observations was reviewed weekly by the ward's MDT. However, inspectors were concerned that the presence of two staff at all times was not clinically required. An area for improvement to review the level of observations required has been made.
- A staff member whom the patient had identified as someone they did not wish to work with them had been reassigned and did not provide any direct care to the patient.
- Visits continued to be supervised.
- The patients care records indicated that they had a long history of unexplained scratches and marks. As a result body charts were being completed by two staff each morning and evening. Over the period 15 to 22 November 2018 there was limited variation of

presenting marks. Inspectors were concerned that this level of body mapping was overly intrusive. An area for improvement has been made to review the level of body mapping for this patient. Inspectors also suggested that the use of the body charts should be reviewed by the safeguarding team to ensure that the patient's capacity and right to privacy is considered alongside the necessity of completing the body charts. The patient was residing in a separate living space within Cranfield Ward 1. Close circuit television (CCTV) was not available in the patient's living room and dining room areas. The ward social worker and ward manager confirmed that there are plans to install CCTV in the two areas.

It was the view of inspectors that Trust staff had adhered to the regional adult safeguarding policy and procedures. Areas for improvement in relation to the level of enhanced observations and the frequency of completing body maps have been made.

The allegation that ward staff and the Trust were not following proper procedures in relation to safeguarding the patient was not substantiated.

The Patient's care and treatment

The patient's living space was located in a private area within the ward. The area had a bedroom with en-suite facilities, an activity room/ living room and dining room. The area had its own entry from outside and could also be accessed through the ward.

A range of MDT assessments were in place. These included assessments and care plans for communication, behaviour and needs, physical health, psychology, nutritional needs, activities of daily living and day time activities. Each assessment was comprehensive and based on the patient's presenting needs.

Ward staff complete daily reviews of the patient's progress and circumstances. Reviews included; a fluid and food intake record, elimination records, antecedent behaviour and consequence (ABC) charts and an exit strategy to ensure consistency by staff when they need to leave the room as a result of the patient becoming unsettled.

Inspectors noted that there was MDT involvement in the patient's care and treatment. However, no one individual staff member had complete oversight of the patient's circumstances and progress. It is recommended that the MDT identify a named worker who will review all of the patient's assessments, reviews, daily monitoring records and daily evaluation. The named worker will help ensure consistency of approach in providing the patient's care and treatment and in reporting to the MDT.

The patient had a number of physical health concerns. Care records detailed that appropriate medical assessments and required treatments had been completed. The patient's records detailed a history of the patient presenting with marks and scratches. The history dated back to 2012 when concerns regarding marking were reviewed by paediatric services. The records indicated that there were multiple cuts on the patient's arms and legs currently as a result of them picking their skin.

The patient continued to be reviewed by the dietician and was prescribed dietary supplements in an attempt to support weight gain. A care plan detailed that the patient's weight should be monitored weekly and bowel movements and fluid / food intake should be monitored daily.

Inspectors were concerned to note that the patient's weight, food/fluid intake and bowel movements had not been monitored consistently. It was not clear if the patient's weight, food/fluid intake and bowel movements had been reviewed by the MDT. An area for improvement with respect to the monitoring of patients physical health care needs and action taken as necessary has been stated for a second time.

It is has also been recommended that the MDT identify a staff member who will have full oversight of the patient's assessments including: mental health, physical health monitoring, behaviour support and discharge planning. This will support an overall view of the patient's presentation and allow greater opportunity to assess potential casual factors between the patient's behaviour and their physical health.

Despite the patient being ready to be discharged from the ward a suitable community placement was not available. Ward staff maintained ongoing contact with their colleagues in the community teams and potential placement providers continued to be assessed. The Trust ensured that the Health and Social Care Board remained informed regarding the patient's circumstances.

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.

Total number of actions for improvement	Four

The four areas for improvement comprise of two new areas for improvement and two areas for improvement which will be stated for a second time. These are detailed in the Quality Improvement Plan (QIP).

Areas for improvement and details of the QIP were discussed with the ward manager and ward staff as part of the inspection process. The timescales for completion commenced from the date of inspection.

Escalation action did not result 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/

5.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the quality improvement plan (QIP). Details of the QIP were discussed with the 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.

5.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Mental Health (Northern Ireland) Order 1986 and The Quality Standards for Health and Social Care DHSSPSNI (March 2006).

5.2 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 to RQIA via the web portal for assessment by the inspector by **15 March 2018.**

Quality Improvement Plan

The responsible person must ensure the following findings are addressed:	
Area for Improvement No. 1 **Ref:** Quality Standard 5.3.1 (c) **Stated:** First time **To be completed by**: Immediate and ongoing	The ward's MDT must ensure that enhanced observations prescribed to patients are proportionate, appropriate and based on the patient's assessed needs. **Response by responsible individual detailing the actions taken:** In response to this area of improvement, enhanced observations prescribed to patients are discussed at the MDT meeting each week to ensure they are proportionate, appropriate and based on the patient's assessed needs. This is recorded on the MDT case conference record.
Area for Improvement No. 2 **Ref:** Criteria 5.3.3 (b) **Stated:** First time **To be completed by:** Immediate and ongoing	The ward's MDT should identify one member of staff to review all of the patient's assessments, care plans, behaviour plans, daily monitoring records (including body maps) and daily evaluations. This will help ensure consistency in the provision of care and during reviews of the patient's progress. **Response by responsible individual detailing the actions taken:** In response to this area of improvement, all patients have a named nurse and an associate nurse responsible for reviewing the patient's assessments, care plans, behaviour plans, daily monitoring records (including body maps) and daily evaluations.
Area for Improvement No. 3 **Ref:** Quality Standard 5.3.1 (a) **Stated:** Second time **To be completed by:** Immediate and ongoing	It is recommended that patient's physical health care needs are routinely assessed by relevant health care staff and the necessary actions are taken to address any identified deficits. All relevant interventions must be appropriately documented in the patient's health care records. **Response by responsible individual detailing the actions taken:** In response to this area of improvement, the ward is developing a physical health pathway to supplement the nursing assessment, based on NICE guidelines. The named nurse will routinely assess on admission and on specified times based on individual need and any necessary actions are taken to address any identified deficits. All relevant interventions are appropriately documented and reviewed in the patient's plan of care. Medical entries on Paris are now recorded in Casenote (medical) and are easily assessable.
Area for Improvement	It is recommended that a system should be put in place by the MDT to

No. 4 **Ref:** 5.3.1 (a) **Stated:** Second time **To be completed by**: Immediate and ongoing	ensure that bowel and weight management care practices and recordings are consistent and adhered to.
	Response by responsible individual detailing the actions taken: In response to this area of improvement, if a patient has an identified need relevant to elimination, a paper record of bowel movement is completed for the duration an intervention is required. If a patient is independent re elimination, this will recorded in their notes and staff ask re bowel movements, easy read documentation is available if required. Weight management is recorded at a minimum of monthly in the assessment details of the patients LD nursing assessment.

Please ensure this document is completed in full and returned to RQIA via the web portal

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