Mental Health and Learning Disability Inpatient Inspection Report
6 - 8 December 2016

Cranfield ICU

Muckamore Abbey Hospital
1 Abbey Road
Muckamore
Co. Antrim

Tel No: 02895042066

Inspectors: Audrey McLellan and Dr Brian Fleming

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 ICU is a six bedded mixed gender ward. The purpose of the ward is to provide assessment and treatment to patients with a learning disability who need to be supported in an intensive care environment. On the days of the inspection five patients on the ward were detained under the Mental Health (Northern Ireland) Order 1986. There were three patients whose discharge from hospital was delayed.

Patients receive input from a multidisciplinary team which includes a consultant psychiatrist, two sub-consultant grade doctors, nursing staff, a behaviour support nurse and a social worker. A patient advocacy service is also available. Patients can access occupational therapy (OT) through a referral system.

3.0 Service Details

Responsible person: Martin Dillon
Ward manager: Sean Murray
Person in charge at the time of inspection: Sean Murray

4.0 Inspection Summary

An unannounced inspection took place over three days from 6-8 December 2016.

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 Cranfield ICU was delivering, safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in relation to the governance arrangements in place, the person centred care provided to patients, the standard of patients' care documentation, patients' access to activities on the ward and in the day centre and the positive working relationships within the multidisciplinary team (MDT). It was good to note that there was evidence that physical interventions were used as a last resort given this ward supports patient who are in crisis. Staff demonstrated a good understanding of restrictive practices and gave examples of how they use de-escalation techniques before any physical intervention.

Areas requiring improvement were identified in relation to delayed discharges, the completion of care plans from patients' assessed need and the absence of clinical psychology within the MD team.

Concerns were raised in relation to patients' access to screening with regard to their physical health care needs. The trust advised that they have highlighted this gap in service provision to the commissioner and have attended several meetings with the Department of Health (DOH) and the Health and Social Care Board (HSCB) however no progress has been made in relation to this recommendation. Patients are still unable to avail of screening with regard to their physical health care needs. RQIA have discussed this subsequently with the HSCB. The trust will update RQIA in relation to progress in this area of improvement

There were three patients on the ward whose discharge was delayed. This was discussed with the ward manager who advised that at present there are no suitable placements in the community for these patients as they have complex needs and require bespoke care package. RQIA has previously written to the HSCB in relation to the number of delayed discharges in the overall hospital site.

Patients said:

"I attend all meetings with the Dr X……..I meet with my named nurse once a week to have a chat and I find this a good support…….I watch TV, DVD's, listen to music and go for walks with the staff….. food is good….it's alright here",

"The doctors good on this ward…..I use the ward phone but would rather have my own mobile".

Relatives said:

"I would like to see X get off the ward more but I know they are starting to do this…. this ward is very beneficial to X as it is a smaller environment… larger wards do not suit X…. it is very difficult getting a suitable placement in the community for x….. the doctors say she needs a bespoke care package in the community……all nurses are great in all wards in Muckamore but sometimes there is a lack of staff"

"Very helpful staff, we are always kept up to date on X's care and treatment…..X is now going swimming 3 times a week which is great…..the staff phone and update us after every weekly meeting…..we have received support from the behaviour support team they have been out to the house and have put plans in place for when X comes home…..before X is discharge two staff will bring X home for a few hours so this a phased approach….we have only positive things to say about this ward, we are always made to feel welcome we can go with X for a spin in the care and to the cosy corner.

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	7

Findings of the inspection were discussed with trust representatives as part of the inspection process and can be found in the main body of the report.

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 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.

Prior to inspection we review a range of information relevant to the service. This included the following records:

- The operational policy and 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 the inspectors met with four patients, four nursing staff, the consultant psychiatrist, the ward doctor, the ward social worker, the carers advocate and two relatives.

The following records were examined during the inspection:

- Care documentation in relation to three patients
- Multidisciplinary team records
- Policies and Procedures
- Staff duty rota
- Staff supervision templates
- Clinical room records
- Environmental risk assessment
- Health and safety assessment
- Fire safety risk assessments
- Mandatory training records
- Records relation to the monitoring of incidents, accidents and serious adverse incidents
- Records relating to adherence to statutory requirements of mental health legislation
- Records relating to the monitoring of the average length of stay and discharge
- Minutes of patient forum meetings
- Minutes of ward manager meetings
- Minutes of a number of different governance meetings and senior staff meetings
- Safety brief template

- Staff planner record

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

We reviewed the recommendations made at the last inspection. An assessment of compliance was recorded as met/ not met.

6.0 The Inspection

6.1 Review of Recommendations from the Most Recent 13 May 2015.

The most recent inspection of Cranfield ICU was an unannounced type inspection. The QIP was returned and approved by the responsible inspector. This QIP was validated by the inspector during this inspection.

Recommendations		**Validation of Compliance**
Area: 1 **Ref**: 5.3.2 **Stated:** First Time	It is recommended that the Trust review the mechanism on the door in the seclusion room to ensure that it is set to unlock automatically if the fire alarm is triggered.	**Met**
	Action taken as confirmed during the inspection: The inspector discussed this area of improvement with trust representative who had reviewed the seclusion room door. The trust confirmed that if the door opened automatically it would pose a health and safety risk for the patient in the seclusion room and the patients on the ward. They confirmed that any patient who requires seclusion is acutely unwell and will at all times be supervised outside the seclusion room door. The trust confirmed that if the fire alarm was raised staff will assess the most appropriate time and resources requires to open the door safely minimising the potential risk to the patient and other patients in close proximity.	
Area: 2 **Ref**: 4.3 (m) **Stated:** Second Time	It is recommended that the Trust ensures that all staff receive training in relation to capacity to consent to care and treatment to include an understanding of the DHSSPS guidance on decision making and consent for patients who do not have capacity to consent.	**Met**

	Action taken as confirmed during the inspection: The inspectors confirmed that all ward based staff had received up to date training in relation to capacity to consent to care and treatment to include an understanding of the DHSSP guidance on decision making and consent for patients who do not have capacity to consent.	
Area: 3 **Ref**: 6.3.1 (a) **Stated:** Second Time	It is recommended that the Trust reviews the availability of and access to occupational therapy for patients on the ward.	**Met**
	Action taken as confirmed during the inspection: At the time of the inspection there was evidence that patients had received occupational therapy input. Patients are also able to avail of occupational therapy when they attend day care.	
Area: 4 **Ref**: 6.3.1 (a) **Stated:** Second Time	**Action taken as confirmed during the inspection**: It is recommended that the Trust reviews clinical resources for patients on the ward to ensure that screening takes place with regard to patients' physical health care needs.	**Not Met** (This has been highlighted with the HSCB. The trust are not able to meet this recommendation without appropriate funding. This has been removed accordingly)
	The trust advised that they have highlighted this gap in service provision to the commissioner and have attended several meetings with the Department of Health (DOH) and the Health and Social Care Board (HSCB) however no progress has been made in relation to this area of improvement. Patients are still unable to avail of screening with regard to their physical health care needs. RQIA have discussed this subsequently with PHA who are addressing this directly with the HSCB. The trust have agree to update RQIA of progress made in this area of improvement.	

7.0 Review of Findings

7.1 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

There was evidence in the three care records reviewed that patients and their carers had been involved in completing their risk assessments and management plans.

Risk assessments were individualised, comprehensive and were used to inform care plans.

Protection plans were in place when safeguarding incidents occurred on the ward and these were reviewed regularly.

An incident occurred on the ward during the inspection. The incident was observed by inspectors to be managed safely and effectively.

The ward had an environmental ligature risk assessment which had no action plan as no ligatures were identified on the ward.

A health and safety assessment had been completed in July 2015 and was due to be reviewed in July 2017.

The ward had a fire risk assessment with an action plan completed in August 2016.

Staff who spoke with the inspectors confirmed they knew who to contact if they had any concerns regarding the ward.

All staff stated they had no concerns regarding the care of patients on the ward.

Staff who met with the inspectors stated they felt well supported on the ward and that the MD team worked well together.

A ‘Safety Briefing’ template was completed every morning and was shared with all staff working on the ward including ancillary staff.

Staff knew the procedure to follow if they had any concerns in relation to patients’ safety on the ward.

Staff confirmed they do not work beyond their role and experience.

There was evidence that patients' rights had been explained to them when they had been detained in accordance with the Mental Health (Northern Ireland) Order 1986.

There was information available on the detention process, patients' rights and how to make a referral to the Mental Health Review Tribunal (MHRT).

Staff who spoke with the inspectors demonstrated how they gained consent from patients prior to supporting them with their care and treatment.

The BHSCT completed a quarterly spot check on detention forms. In October 2016 there were no recommendations identified for Muckamore Abbey Hospital Staff.

Patients confirmed they knew how to make a compliant and information regarding how to make a complaint was detailed in the ward information booklet.

Areas for Improvement

No areas for improvement were identified during the inspection.

Number of areas for improvement	**0**

7.2 Is Care Effective?

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

Areas of Good Practice

Comprehensive assessments were completed and care plans were devised from these assessments.

Assessments were person centred and detailed patients' comments which evidenced patients' involvement.

There was evidence of all disciplines recording their involvement with patients onto the PARIS system.

Care plans were individualised and had been completed with patients' involvement. There was evidence that these were regularly reviewed.

There was evidence of Positive Behaviour Support Plans being developed for patients when there was an assessed need. These were reviewed and updated as and when required.

It was good to note some patients had a 'Hospital Passport' in place which was person centred and evidenced patient involvement. This passport detailed patients' support needs and included some of the following titles; "how do I tell you I am in pain, what support I need to make decisions, equipment I use, allergies, medical interventions, heart/breathing problems, risk of choking, other health conditions, hearing/vision/sensory difficulties, support I need for my behaviour, current medication, medical history, how to recognise when I am anxious and how you should help me when I am anxious".

Patients had easy read information available to them to help them understand their care and treatment. These include; communication passports, feelings booklets, all about me booklets, picture exchange communication systems (PECS) and activity pictorial timetables.

There was evidence that patients physical and nutrition needs were assessed.

Patients had individual therapeutic/activity timetables which included outings outside the ward environment.

There was evidence in the care records which confirmed that patients were seen regularly by medical staff outside of the ward round.

There was evidence that nurses had completed a report for the MDT meeting each week this included each patient's progress over the past week.

There was a very comprehensive record of discussions and actions agreed at the MDT meetings this also included a named person and timescale for completion of each action.

It was also good to note that staff contacted patients' family/next of kin each week to update them on the outcome of the MDT meeting. (Relatives who met with the inspectors confirmed this)

There was evidence of OT involvement on the ward and meetings were held with the OT and behaviour support services to review patients' behaviour and to discuss strategies.

There was evidence in the patients records of referrals made to speech and language therapy (SALT), dietetics, podiatry, behaviour support services, social work and OT.

Patients attended day care each week when this was assessed as appropriate.

Progress notes were very detailed and gave a good description of patients' progress on the ward.

Care plans were in place for patients' day care placements and there was good recording in the day care progress records of patients' participation in activities, (individual and group) patients' presentation and behaviour throughout each session.

Comprehensive seclusion reports were completed which detailed the time seclusion commenced the efforts and methods made to try and prevent seclusion i.e. encouraged to relax in room, personal hygiene attended to, assisted with a bath, given patient a drink, PRN medication and walks outside. There was a detailed account of the incident which included the patients' presentation throughout the period of seclusion.

There were plans in place for one patient to be discharge to a supported living establishment. The inspector discussed this process with the patient who confirmed that they had been involved in their discharge planning and plans were in place for them to view this new placement.

Patients were observed coming and going from the ward throughout the days of the inspection. Patients appeared relaxed in the ward environment.

The ward was clean, clutter free and maintained to a high standard.

The ward had a small 'sensory modulation room' which patients could use to relax in and listen to music. This room had fibre optic lighting and a massage chair.

The ward manager and senior trust representatives were in the process of redesigning the seclusion room to include a low sensory area with the aim of reducing the number of patients requiring seclusions in the future.

Deprivation of liberty care plans were in pace which were person centred and reviewed regularly.

It was good to note that bi-monthly restrictive practice meetings were held to discuss episodes of seclusion, PRN medication and other restrictive practices on the ward.

Staff who spoke to inspectors had a good understand of restrictive practice, supporting patients who present with behaviours that challenge through the use of positive behaviour support plans which include incentive plans and proactive strategies.

Areas for Improvement

In two sets of care records there were a number of care plans that had not been completed when there had been an identified need.

Malnutrition Universal Screening Tool (MUST) assessments were completed for patients and when they were assessed as low risk it stated in the care records that they should be reviewed monthly as per trust policy but these were not reviewed on a monthly basis.

There was a section on the PARIS system to record weekly 1:1 therapeutic intervention by nursing staff. However, a number of staff had recorded this intervention in the progress records. Therefore it was difficult to track the patients' progress.

The majority of patients transfer to Cranfield ICU from another ward on the hospital site and then transferred back to the ward they were admitted from. It was difficult to ascertain on the PARIS system the date when patients were admitted onto Cranfield ICU.

Number of areas for improvement	**4**

7.3 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

All interactions observed between staff and patients were observed as very positive.

An incident occurred on the ward during the inspection which was observed by the inspector this was dealt with very quickly with the least disruption to other patients.

Staff were observed attending to patients needs when they were distressed and required emotional support.

All three patients who met with the inspectors confirmed that they were treated with dignity and respect by all staff who were involved in their care and treatment.

Patients were seen coming and going form the ward/going out with family members, over to day care centre and the cosy corner restaurant.

Patients stated staff listen to their views and wishes.

Patients stated they could have support at meetings if requested.

There was evidence of information shared with patients and patients were asked if they wanted to attend their MDT meetings when this was appropriate.

There was evidence in the patients' care records of staff meeting with patients after the MDT meeting if they had not attended to update them on the outcome of the meeting.

Patients who spoke to the inspector confirmed that staff involved them in decisions about their care and treatment.

Patients confirmed that when restrictive practice was used staff met with them afterwards to discuss this with them.

Patients who met with the inspector advised that they were very happy with their care and treatment on the ward.

The inspectors met with two family members who advised they were very happy with the care and treatment their relative was receiving on the ward.

Advocates attended the ward on request.

There was a carers advocacy who was supporting a number of patients' relatives.

Areas for Improvement

No areas for improvement were identified during the inspection.

Number of areas for improvement	**0**

7.4 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

All staff who spoke to the inspectors knew what actions to take if they had concerns regarding patients care and treatment on the ward.

Governance arrangements were in place to monitor the use of medication.

Bi-monthly meetings were held to monitor and review the use of PRN medication.

Patients' medication was reviewed each week at the MDT meetings.

Policies and procedures relating to the ward were up to date.

A Learning Disability Service Dashboard is completed every three months and part of this reviews patients' average length of stay, overall occupancy and patients' discharge arrangements including delayed discharge.

The ward manager completed a monthly audit on the number of patients admitted and discharged from the ward, the bed occupancy and patients average stay on the ward.

All incidents, accidents, SAI's and whistleblowing concerns were recorded on the DATIX system. These are then automatically sent to the relevant line managers, head of services, relevant professionals and the risk management team via an email to alert them to the incident.

There was evidence that staff were analysing information so that services could be improved.

All staff who were interviewed by the inspectors stated that the MDT worked well together.

A number of audits were completed on a monthly basis by the ward manager which included, incidents, complaints, compliments, vulnerable adult referrals, staff sickness, admissions and discharges.

Patient satisfaction surveys were completed bi-monthly.

There was a 'Daily Planner' which recorded staffs' roles throughout their shift.

The ward manager completed monthly audits of the PARIS records.

The ward manager completed a quality monitoring report every month to discuss with the senior nurse manager.

The senior nurse manager completed a quality report following unannounced visits to the ward.

A learning disability service governance meeting is convened every two months.

Learning from incidents was disseminated to staff through a number of mechanisms. Staff received an email which detailed the outcome of the incident and the ward had also commenced reflective practice sessions with staff.

The ward has a daily schedule/checklist which included duties that needed completed by staff.

The MDT monitored the use of restrictive practice on a bi-monthly basis. They discussed and analysed trends with the focus on reducing the number of incidents of restrictive practices on the ward.

A Learning Disability Service Group Management Board Dashboard is completed every three months.

There had been three informal complaints to the ward over the past year. One from a patient and two from relatives. All three complaints were resolved to the complainants' satisfaction.

Patients completed a satisfaction survey every two months and the outcome of the survey was displayed on the ward's notice board.

There was a defined organisational and management structure in place. Staff who spoke to the inspectors were aware of this structure.

Staff from the MDT who met with the inspectors confirmed that they had up to date appraisals in place and received supervision as per their per professional / governance guidance.

Nursing staff who spoke to the inspectors stated they enjoyed working on the ward and stated they were well supported by their colleagues and the ward manager.

No concerns were raised regarding the level of staff on the ward.

The inspectors interviewed members of the MDT and they confirmed that the MDT worked well together.

The staffing levels met the needs of the patients. There were on average five staff on day duty (three staff nurses and two health care assistants)

Bank staff shifts were completed mainly by staff working on the ward. Agency staff had not been used on the ward

There were some gaps in the staffs mandatory. However, the ward had recruited a number of new staff (40%) and were in the process of arranging for these staff members to receive up to date mandatory training.

Areas for Improvement

The minutes of the ward manager's meetings did not evidence that all issues pertaining to the ward had been discussed and reviewed as the minutes were very limited in content

Patient forum meetings were not held on a regular basis on the ward, the minutes of these meetings were not recorded in an easy to ready format and information was not displayed regarding the next patient forum meeting.

There was no clinical psychologist attached to the ward to form part of the MDT

Number of areas for improvement	**3**

8.0 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.

8.1 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 by 1 February 2017.

Provider Compliance Plan Cranfield ICU	
Priority 1	
The responsible person must ensure the following findings are addressed:	
Area for Improvement No. 1 **Ref:** Quality Standard 5.3.1(a) **Stated:** First time **To be completed by:** 5 January 2017	In two sets of care records there were a number of care plans that had not been completed when there had been an identified need.
	Response by responsible person detailing the actions taken: In response to this area of improvement, the 2 sets of records were updated and a plan of care written to meet the identified need.
Area for Improvement No. 2 **Ref:** Quality Standard 5.3.1(a) **Stated:** First time **To be completed by:** 5 January 2017	Malnutrition Universal Screening Tool (MUST) assessments were completed for patients and when they were assessed as low risk it stated in the care records that they should be reviewed monthly as per trust policy but these were not reviewed on a monthly basis.
	Response by responsible person detailing the actions taken: In response to this area of improvement, the Malnutrition Universal Screening Tool (MUST) assessments are reviewed on a monthly basis
Area for Improvement No. 3 **Ref:** Quality Standard 5.3.1(f) **Stated:** First time **To be completed by:** 5 January 2017	There was a section on the PARIS system to record weekly 1:1 therapeutic intervention by nursing staff. However, a number of staff had recorded this intervention in the progress records. Therefore it was difficult to track the patients' progress.
	Response by responsible person detailing the actions taken: In response to this area of improvement, staff are recording a weekly 1:1 with each patient.
Area for Improvement No. 4 **Ref:** Quality Standard 5.3.1(f)	It was difficult to ascertain on the PARIS system the date when patients were admitted onto Cranfield ICU the ward.
	Response by responsible person detailing the actions taken: In response to this area of improvement, staff now have access to a

Stated: First time **To be completed by:** 5 January 2017	report on the Paris system which shows when patients were admitted onto Cranfield ICU the ward.
Priority 2	
Area for Improvement No. 5 **Ref:** Quality Standard 4.3 (a) **Stated:** First time **To be completed by:** 2 February 2017	The minutes of the ward manager's meetings did not evidence that all issues pertaining to the ward had been discussed and reviewed as the minutes were very limited in content.
	Response by responsible person detailing the actions taken: In response to this area of improvement, the Ward Manager has updated the meeting proforma to capture all issues pertaining to the ward that have been discussed and reviewed
Area for Improvement No. 6 **Ref:** Quality Standard 8.3 (a) **Stated:** First time **To be completed by:** 2 February 2017	Patient forum meetings were not held on a regular basis on the ward, the minutes of these meetings were not recorded in an easy to ready format and information was not displayed regarding the next patient forum meeting.
	Response by responsible person detailing the actions taken: In response to this area of improvement, patient meetings are now recorded in an easy to read format and information is displayed regarding the next patient forum meeting.
Priority 3	
Area for Improvement No. 7 **Ref: 4.3 (j)** **Stated:** First time **To be completed by:** 8 June 2017	There was no clinical psychologist attached to the ward to form part of the MDT.
	Response by responsible person detailing the actions taken: In response to this area of improvement, the hospital service manager is reviewing the psychology input into the ward with the Trust's Psychology Manager and an action plan will be developed.

Name of person(s) completing the provider compliance plan	Sean Murray		
Signature of person(s) completing the provider compliance plan		**Date completed**	January 2017

Name of responsible person approving the provider compliance plan	Martin Dillon		
Signature of responsible person approving the provider compliance plan		**Date approved**	January 2017
Name of RQIA inspector assessing response	Audrey McLellan		
Signature of RQIA inspector assessing response		**Date approved**	9 March 2017

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