Unannounced Follow Up Inspection Report
24 October 2017

Erne Ward 1

Resettlement Ward
Muckamore Abbey Hospital
1 Abbey Road
Antrim
BT41 4SH

Tel No: 028 95042087

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

Erne Ward 1 is a seven bedded resettlement unit for male patients who have a learning disability. On the days of inspection there were five patients on the ward.

There were no patients on the ward detained in accordance with the Mental Health (Northern Ireland) Order 1986.

Care was provided by a multi-disciplinary team that included nursing, medical, psychiatry, and occupational therapy. An activity coordinator also provided a service to patients. Patients' had access to behavioural support and psychology services via referral. Independent advocacy services also visited the ward.

3.0 Service details

Responsible person: **Martin Dillon**	**Ward Manager:** **Rhona Brennan**
Category of care: Resettlement	**Number of beds: Seven**
Person in charge at the time of inspection: Rhona Brennan	

4.0 Inspection summary

An unannounced follow-up inspection took place on 24 October 2017.

The inspection sought to assess progress with findings for improvement raised from the most recent previous unannounced inspection 19-21 July 2016.

It was good to note that progress was made with all 12 areas of improvement from the inspection in July 2016. The ward had a relaxed, calming and welcoming atmosphere. The ward environment had undergone significant improvement in its presentation, hygiene and cleanliness. The ward was decluttered and flooring had been replaced in some areas and new furniture had been purchased. Patients' bedrooms were personalised and each patient had a personalised activity plan in place. Information and signage were presented in a format compatible with patients communication needs. New white boards had been ordered and placed throughout the ward to share information with patients and carers. There was evidence that significant improvements were made with care documentation and new structures were implemented to assist in sharing of information with staff. There was also evidence that relationships between the members of the multi-disciplinary, cleaning services and estate services had improved and developed. Cleaning staff reported that there was a team approach to maintaining hygiene standards on the ward.

Staff reported that they felt supported and were part of a “great team and that the manager, deputy manager and operations manager were supportive approachable and helpful”. Staff also reported that they believed patients now experienced a better quality of life.

Two patients were able to inform the inspector what activities they were about to complete. Patients appeared relaxed and at ease and were dressed appropriate for the weather. There was evidence that staff had detailed knowledge of patient’s needs.

Patients said,

The inspector met with three patients. All three patients reported they were happy with the care and treatment they received on the ward. One patient said he was delighted to have a key to his own bedroom.

"I like my room but I want to get my own home."

"I like it here"

"I go horse riding and like to go out for a drink."

"It's alright" (Patient response to the question; How they like being on the ward?)

"I am going shopping today and getting my hair cut.”

“I am going to the day centre.”

Relatives said,

There were no relatives on the ward during the inspection.

Staff said,

The inspector met with five members of the nursing staff team, one member of cleaning staff, and one visiting professional during the inspection. All comments received were positive in relation to the changes on the ward. Staff reported there was a more cohesive team on the ward and all members of staff felt valued. S taff reported there was good leadership on the ward.

“We are all working as a team.”

“Patients have a better quality of life now.”

“It’s a great team and there is great support.”

“The debriefing in the morning is really good. We can discuss any issues that have happened and everyone is involved in the safety debrief.”

“It’s the simple things we had to get right. Once we keep up with the schedules it’s easy to keep on top of things.”

"The reason it works is because everyone does their share of cleaning."

"Management is very approachable and very helpful. I have found them helpful in terms of my personal and professional development"

Staff were commended on the significant progress made in all twelve areas of improvement. The inspector noted and acknowledged with staff their effort, commitment, cooperation and the cohesiveness in bringing about such positive changes.

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	0

There were no areas identified for improvements during this 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:

- Fire safety assessments.
- Patient forum meetings.
- Staff duty rota.
- Daily allocation sheets.
- Care documentation in relation to three patients.
- Ward environment.
- Advocacy service.
- Activity schedule.
- Minutes of staff meetings.
- Environmental assessments.
- Emergency equipment checks.
- Safety briefing records.
- Patient finance records.
- The management and storage of confidential records.
- Ward performance records and audits.

- Feedback from six staff.
- Observations of staff practice and engagement with patients.

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

6.0 Review of areas for improvement from the last unannounced inspection 19-21 July 2016

The most recent inspection of Erne Ward 1 was an unannounced inspection. The completed Quality Improvement Plan (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**: Standard 5.3.1 (e) **Stated: First Time**	**The responsible person must ensure that:** All urgent actions identified in the fire risk assessment are addressed. Patient's personal emergency evacuation plans are updated and regularly reviewed. Staff are aware of and can respond appropriately to each patient's individual needs in the event of a fire. Staff that come to assist in the event of a fire are given clear guidance and direction. Emergency exits are free from obstruction.	**Met**
	Action taken as confirmed during the inspection: The inspector examined the fire risk assessment and associated action plan, fire training and fire drill records. There was evidence in the records that the majority of action points highlighted on the fire risk action plan had been addressed. There were a number of action points which were placed on the	

	corporate risk register as they required capital funding to action. This issue was discussed in detail with the business manager. The Belfast Trust has a process of risk assessing where capital funds money will be spent. Testing of emergency lighting was issued to a third party for inspection and the five year checks were scheduled for inspection during this year. Evacuation procedures had been reviewed and had been changed from horizontal evacuation to full evacuation. All staff had up-to-date fire training and there were seven members of the Erne staff team who received additional training as fire wardens. All staff were familiar with fire evacuation procedures. Patient emergency evacuation plans were updated and reviewed outlining the support needs of patients in the event of a fire. There were two evacuation fire drills completed on 27 January 2017 and 6 July 2017. Four patients refused to leave the ward on 27 January 2017 and two patients refused to leave the ward on 6 July 2017. The Belfast Trust has a process in place in accordance with their fire training policy to manage situations where patients refuse to leave the building. The fire officer visited the ward on 12 September 2017 and completed a walk/talk fire drill with staff. Emergency exits were observed to be free from obstruction on the days of the inspection. Staff were allocated the responsibility on a daily basis to check the environment for any fire safety issues. Escape routes, fire detectors, emergency exits and emergency fastening devices were routinely checked every week. Fire extinguishers, fire doors and closing devices were routinely checked every month.	
Area for	**The responsible person must ensure that:** The resuscitation trolley and other emergency	**Met**

improvement 2 **Ref**: Standard 5.3.1 (f) **Stated: First Time**	equipment is checked in accordance with the Trust's policy.	
	Action taken as confirmed during the inspection: The inspector reviewed the check lists in relation to the resuscitation equipment. There was evidence that the equipment had been checked in accordance with trust policy.	
Area for improvement 3 **Ref**: Standard 5.3.1 (f) **Stated: First Time**	**The responsible person must ensure that:** The hygiene, maintenance and tidiness of the ward are improved and maintained to a satisfactory level. Patient's privacy, dignity and comfort are upheld and enhanced by the provision of appropriate clothing, soft furnishings, window coverings, mattresses and garden shelter.	**Met**
	Action taken as confirmed during the inspection: The inspector observed the ward environment and noted it had significantly improved. Nursing and patient experience staff had a shared understanding and commitment to cleaning schedules. The ward was clean, tidy and clutter free. New flooring had been purchased for the dining room and new furniture was evidenced throughout the ward. Window coverings were in place and all beds had a properly fitted mattress with appropriate and comfortable bedding. Patient rooms were personalised. Patients were noted to be suitably dressed to suit the weather conditions and the temperature of the ward. The garden area had been cleaned and maintained. There was appropriate shelter outside for patients.	
Area for improvement 4	**The responsible person must ensure that:** Staffing levels in Erne Ward reflect the needs of the patients, to include safe supervision, address the environmental design and ensure patients have	

Ref: Standard 5.3.3 (d) **Stated: First Time**	access to planned activities. **Action taken as confirmed during the inspection**: On the days of the inspection there were five patients on the ward. Each patient required assistance with their daily living needs and required different levels of supervision. Levels of supervision on the ward ranged from general observations to two to one observation. Erne Ward 1 has four separate communal areas. Three patients each have separate living areas with a bedroom, bathroom and living/ dining area to accommodate their specific care needs. The ward manager stated that the ward required a minimum of nine staff per shift due to supervision levels and environmental design with a minimum of three qualified staff. There are occasions when staffing numbers were reduced to seven staff per shift however this is generally planned in accordance with patient routine and home visits. On occasions due to casual sickness, the shortfall is reported immediately to the Nursing Office as per protocol. This was monitored and reviewed by trust senior managers. There was no evidence that hospital appointments were cancelled due to staff shortages. Ward based activities continued and patients continued to attend day care every day. Duties were allocated on a daily basis to ensure that the needs of the patients were met and patients were supervised. A safety briefing was also completed every day and there was evidence that housekeeping were informed of any risks on the ward.	**Met**
Area for improvement 5 **Ref**: Standard 5.3.1 (a) **Stated: First Time**	**The responsible person must ensure that:** Assessments, care plans and risk assessments are thorough, up-to-date, reflect changing needs and specialist assessments. Care plans are evaluated, reviewed and recorded in a timely manner in accordance to trust, regional policies and professional guidance.	**Met**

	Progress notes are accurate, complete and are easily accessible to all staff delivering care.	
	Action taken as confirmed during the inspection: The inspector reviewed care documentation in relation to three patients. Assessments, care plans and risk assessments were recorded on the patient electronic recording system (PARIS). Assessments had been reviewed and were noted to be up to date. Care plans were person centred and underwent regular review and reflected the assessed needs of the patients. Each patient had a completed risk screening tool in place. These were noted to be completed in accordance with Promoting Quality Care – Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services May 2010. Any risks identified were recorded and managed through the patient's care plan. Elements of restrictive practices were recorded in assessments and care plans. These were reviewed and terminated when they were no longer required demonstrating adherence to best practice. Case notes and daily progress notes were detailed, and person centred. There was evidence in case notes that family members were kept informed and up-to-date on each patient's progress. The consultant psychiatrists and medical staff were recording their involvement in patients' care and treatment on the PARIS system.	
Area for improvement 6 **Ref**: Standard 5.3.1	**The responsible person must ensure that:** Patient financial transactions are in accordance with trust policies and procedures.	**Met**

(c) **Stated: First Time**	**Action taken as confirmed during the inspection**: The inspector reviewed the financial records pertaining to all patients on the ward. Robust checking mechanisms were in place and it was noted that there was good adherence to the Trusts financial policies and procedures. Patients' monies that were held on the ward were checked by two staff every morning and evening. Financial records were audited by the ward manager every week and by the senior nurse manager every three months.	
Area for improvement 7 **Ref**: Standard 6.3.2 (a) **Stated: First Time**	**The responsible person must ensure that:** Patients have; • Access to advocacy on the ward. Advocates should take into consideration the communication support needs of the patients. • Patient representative forum meetings which are recorded and ensure all actions identified are followed up.	**Met**
	Action taken as confirmed during the inspection: It was pleasing to note that access to advocacy services had improved for patients on Erne Ward 1. Photograph of advocates are displayed. The ward notice board identifies the advocate for each individual patient. Advocates visit the ward on a weekly basis. Dates of patient forum meetings are displayed on the ward notice board and minutes are available for review and actions followed up. A new easy read template was designed to capture patient related issues. This template is completed with patients prior to the monthly patient forum.	
Area for improvement 8 **Ref: Standard6.3.2 (a, b & c)**	**The responsible person must ensure that:** Patients have information in a format that meets the communication needs of patients to; • assist in orientation around the ward, • know who is on duty and,	**Met**

Stated: First Time	• what activities are on offer. **Action taken as confirmed during the inspection**: There was appropriate signage displayed throughout the ward to help orientate patients. This was in a format appropriate to patient's communication needs. There were photographs displayed of multidisciplinary staff on duty each shift. Each patient had an individual activity schedule which was depicted in symbols/ photographs. The inspector spoke to two patients who were aware of their activity schedule and who were able to inform the inspector of their respective activity for that afternoon.	
Area for improvement 9 **Ref**: Standard 5.3.1 (f) **Stated: First Time**	**The responsible person must ensure that:** Patient records and files are managed and stored in accordance with trust and data protection policies and procedures and Nursing Midwifery Council guidance on record keeping. **Action taken as confirmed during the inspection**: All members of the multidisciplinary staff record on the PARIS system which is a secure electronic record of patient notes. In addition each patient had a hard copy medical file which contained hardcopy information that could not be recorded in a digital format such as lab results etc. These files were kept in accordance with trust and data protection policies and procedures and Nursing Midwifery Council guidance on record keeping. Hardcopy files were stored in a secure filing cabinet in the main office.	**Met**
Area for improvement 10 **Ref: Standard 5.3.1 (f)** **Stated: First Time**	**The responsible person must ensure that:** The ward's performance is audited and outcomes are displayed for patients' carers, relatives and staff. **Action taken as confirmed during the inspection**:	**Met**

	The inspector noted the wards performance was displayed on the main notice board for patients, relatives and carers. Information displayed related to the number of incidents, safeguarding referrals, complaints and compliments and minutes of patient forum outcomes.	
Area for improvement 11 **Ref**: Standard 6.3.2 (b) **Stated: First Time**	**The responsible person must ensure that:** Relatives are informed in advance of the purpose of meetings. **Action taken as confirmed during the inspection**: There were no relatives available on the day of inspection however the ward manager advised that medical records department are now charged with the responsibility of writing out to relatives in advance of a meeting inviting them to attend and outlining the purpose of the meeting. The inspector also noted reference to letters for carers in patient files.	**Met**
Area for improvement 12 **Ref: Standard 5.3.1 (e)** **Stated: Second Time**	**The responsible person must ensure that:** There is a ward specific environmental assessment completed and an action plan is completed which should include a timeframe / responsible person for action. **Action taken as confirmed during the inspection**: An environmental check was completed every day by allocated staff. Any areas requiring attention were identified, recorded and addressed promptly. The inspector reviewed the jobs request book which evidenced appropriate action taken. There was evidence that senior management attended the ward every week to review the environment.	**Met**

7.0 Actions to be taken by the service

There were no areas for improvement identified during this inspection, and a provider compliance plan is not required or included, as part of this inspection report.

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