Whistleblowing Inspection Report
20 December 2017

Cranfield Ward 2
Muckamore Abbey Hospital
1 Abbey Road,
Muckamore,
BT41 4SH
Tel No: 02895 042063

Inspectors: Wendy McGregor and Audrey McLellan

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 2 is a 15 bedded ward with an additional apartment (on another ward) 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. Three patients were detained in accordance with the Mental Health (Northern Ireland) Order 1986.

3.0 Service details

Responsible person: **Martin Dillon**	**Ward Manager:** **Linda McCartney**

4.0 Inspection summary

A Whistleblowing inspection took place on 20 December 2017.

The inspection was undertaken in response to the following concerns raised from an anonymous telephone call to the RQIA office.

1. Unsafe staffing levels.
2. Staffing levels were not in place to address the number of patients in receipt of enhanced observations / supervision.
3. The effect of low staffing levels on the number and nature of incidents.
4. Adherence to the Belfast Health and Social Trust Policy Levels of Supervision/observation within Learning Disability Inpatient Services (November 2013).

RQIA contacted the Acting Head of Learning Disability Services and informed them of the concerns raised by the anonymous caller. RQIA requested that the Trust forward the minimum staffing levels per shift, the staffing levels obtained and information in relation to the number of patients who required enhanced observations.

On receipt and analysis of this documentation RQIA requested additional information and a decision was made to visit the hospital to complete an announced Whistleblowing inspection.

Specific methods/processes used in this inspection included the following:

- Review and analysis of incidents and accidents, duty rotas, complaints and staff absence levels.
- Review of the Belfast Health and Social Trust Policy on Levels of Supervision/observation within Learning Disability Inpatient Services (November 2013).
- Discussions with Trust senior management and the ward manager.
- Examination of care records in relation to seven patients who were in receipt of enhanced observations or supervision.
- The day care schedule.
- Review of the risk register.

Any other information received by RQIA about this service and the service delivery was also considered by inspectors in preparing for this inspection. Findings in relation to the allegation are discussed below.

4.1 Inspection outcome

Inspectors examined the ward's situation in relation to the allegations made by the anonymous caller. The nature of the allegations and the inspectors findings are detailed below.

1. Unsafe staffing levels.

Inspectors reviewed ward occupancy levels and staffing levels from 9 October 2017 to 5 November 2017. Inspectors also reviewed staff absence.
In respect of ward occupancy levels the ward has been 100% occupied in this period.

The number of staff required for safe staffing levels on the ward is as follows:

- 0730 – 1315hrs = 10 staff
- 1300 -2030hrs = 10 staff
- 2000 – 2300hrs = 8 staff
- Night duty = 5 staff

Inspectors noted that 51% of shifts had not achieved the required staffing levels. In RQIA's view this percentage is high and there would be concerns in relation to safe and effective care if this was happening on a regular basis.

Inspectors noted that staffing levels have improved since 20 November 2017. Since this date three staff nurses who were working as health care assistants had received their Nursing and Midwifery Council (NMC) PIN numbers and commenced their staff nurse post and three staff have been redeployed to Cranfield Ward 2 from another ward that had recently closed. The ward manager and two deputy ward managers had returned after a period of absence and overall staff absence had reduced.

Inspectors reviewed the ward duty rota ward from 6 December 2017 to 20 December 2017 and noted an improvement in staffing levels. It was also noted that the number of shifts that did not achieve the required staffing levels had reduced to 29% of shifts.

There was evidence of robust governance mechanisms in place to monitor staffing levels. The inability to meet minimum staffing levels was assessed as a high risk on the Trust's directorate risk register. Ward staff reported staffing shortages to the senior nurse manager, the duty officer and recorded it as an incident on the incident recording system (DATIX). All attempts were made to address staff shortages through the use of bank staff and agency staff.

This allegation was substantiated. Staffing levels remain a concern for the Muckamore site as there are some shifts that do not achieve the required staffing levels. However, there was evidence that staffing levels had improved due to a reduction in staff absence and redeployment of staff from a recently closed ward. There was evidence of ongoing recruitment of staff for Muckamore.

2. Staffing levels were not in place to address the number of patients in receipt of enhanced observations / supervision.

On the day of the inspection, inspectors confirmed that seven out of 16 patients required different levels of enhanced observations or supervision which were recorded as follows:

- Patient A - 24 hour one to one support in an acute general hospital.
- Patient B – 24 hour level 3 within eyesight due to aggression towards self and others.
- Patient C – Level 3 within eyesight when in communal areas. Level 2 observations (15min checks) when in their bedroom. Due to disinhibited behaviours and aggression toward others. Inspectors noted that the length of time varied for level 3 support. However it was recorded that the patient prefers to spend much of their day in their bedroom and generally goes to bed around 8.30pm.
- Patents D – Level 3 within eyesight when in communal areas. (Level 1 general observations when in bedroom). Due to disinhibited behaviours and aggression toward others.
- Patient E – 24 hour level 3 within eyesight due to aggression towards others.
- Patient F and Patient G – One to one support during meal times due to risk of choking.

The remaining nine patients were on level 1 general observations.

Inspectors reviewed the care documentation in relation to the seven patients. There was recorded evidence that decisions in relation to enhanced observations or supervision were agreed and reviewed every week by the multidisciplinary team. From the information reviewed it was noted that the rationale for the enhanced observation or supervision was recorded and was proportionate to the assessed risk.

Inspectors noted that on average four patients in the morning and six patients in the afternoon leave the ward to attend day care. Level 3 enhanced observations for patients C and D reduced to level 2 and level 1 observations during the day, when they went to their bedroom. This reduced the pressure on staffing levels.

Inspectors reviewed the duty rota from 6 December to 20 December and noted that staffing levels were in place to meet the needs of patients who require enhanced observation / supervision. **This allegation was unsubstantiated.**

3. The effect of low staffing levels on the number and nature of incidents.

Inspectors reviewed a record of incidents and cross referenced these with the number of staff on duty. There were 78 incidents recorded and reported onto the DATIX system from 9 October 2017 to 26 November 2017. 74% of the incidents were in relation to abuse against staff by patients and 19% of incidents were in relation to patient on patient abuse. A safeguarding vulnerable adult referral was made following each incident of patient on patient abuse.

This allegation was unsubstantiated. There was no correlation between the number and nature of incidents with the number of staff on duty. For example on a day when number of staff working on the ward was below the required number there were no incidents.

4. Adherence to the Belfast Health and Social Care Trust Policy Levels of Supervision and observation within Learning Disability Inpatient Services (November 2013).

Inspectors reviewed staff rotas, the number of patients receiving enhanced observations and the daily allocation sheets from 9 October 2017 to 5 November 2017. During this period of time there was evidence that the policy was not always adhered to as there were not enough staff to rotate during the enhanced observations of patients. However this has improved with the increase in staffing levels. The daily allocation sheets reviewed by the inspectors evidenced that from 6 December 2017 staff providing enhanced observations have been rotated in accordance with the Trust policy and procedure.

This allegation was substantiated for the period of time from 9 October 2017 – 5 November 2017. However this has improved with the increase in staffing levels. The daily allocation sheets reviewed by the inspectors evidenced that from 6 December 2017 staff providing enhanced observations have been rotated in accordance with Trust policy and procedure.

Additional information

It was good to note that there have been no complaints received during the period of 10 September 2017 to 26 November 2017 and staff shortages have not impacted on patients attending day care or attendance any medical appointments.

7.0 Conclusion

Two out the four allegations were substantiated. These are in relation to the provision of safe staffing levels and adherence to the Belfast Health and Social Care Trust Policy on Levels of Supervision and Observation within Learning Disability Inpatient Services (November 2013). Inspectors did not make any areas for improvement as there has been an increase in the number of staff working on the ward due to a decrease in staff absence and redeployment of staff with the closure of Erne Ward 2. The Trust continues to use bank and agency staff and is proactively attempting to recruit staff.

The remaining two allegations were unsubstantiated. Staffing levels were in place to address the number of patients in receipt of enhanced observations / supervision and there was no recorded evidence to confirm that reduced staffing levels had any effect on the number and nature of incidents on the ward.

7.1 Actions to be taken by the service

The responsible person should review the report for factual accuracy and contact the mental health team if required otherwise return the report signed by the ward manager and the responsible person via the web portal by **13 February 2018.**

Name of Ward manager	Linda Macartney		
Signature of Ward manager	Linda Macartney	**Date completed**	18th January 2018
Name of responsible person approving the report	Martin Dillon		
Signature of responsible person approving the report	Martin Dillon	**Date approved**	18th January 2018
Name of RQIA inspector	Wendy McGregor		
Signature of RQIA inspector	Wendy McGregor	**Date approved**	23 January 2018

Please ensure this document is completed in full and returned to MHLD.DutyRota@RQIA.org.uk from the authorised email address

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