Unannounced Inspection Report
28 October 2016

Killead

Type of service: Female Admissions Ward

Address: Muckamore Abbey Hospital
1 Abbey Road
Muckamore
Antrim BT41 4SH

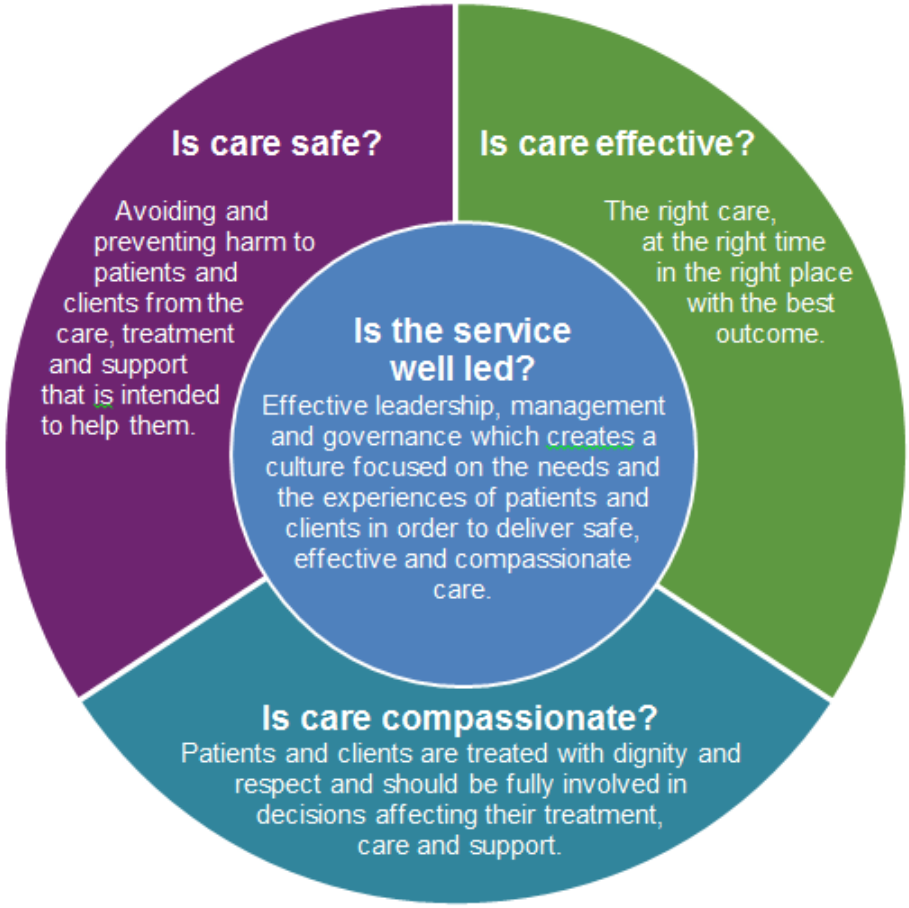
Tel No: 028 95042079

Inspectors: Alan Guthrie, Patrick Convery

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

1.0 What we look for

their responsibility for maintaining compliance with legislation, standards and best practice.



2.0 Profile of Service

Killead ward is a 21 bedded female admission ward on the Muckamore Abbey Hospital site. The purpose of the ward is to provide assessment and treatment to patients with a learning disability who need to be supported in an acute care setting. At the time of the inspection the ward was providing care and treatment to patients from three health and social care trusts. The ward had recently moved location from Cranfield female ward on the 4 July 2016.

Patients within Killead have access to a multi-disciplinary team (MDT) which incorporates psychiatry, nursing, psychology, occupational therapy, behavioural support, speech and language therapy, and social work professionals. Patient advocacy services were also available.

On the days of the inspection there were eighteen patients on the ward and one patient on leave. Inspectors were informed that the discharge of nine patients had been delayed due to a lack of appropriate community resources.

3.0 Service Details

Responsible person: Dr Michael McBride	**Position:** Chief Executive
Person in charge at the time of inspection: Deputy ward manager	

4.0 Inspection Summary

An unannounced inspection took place on the 28 October 2016 from 10:00 to 16:00.

The inspection was undertaken in response to concerns received by RQIA from an anonymous caller. The concerns raised related to the following allegations:

1. Alleged deterioration in a patient's health as a result of the patient being moved from Cranfield female ward to Killead ward.
2. The Killead ward environment was overcrowded.
3. There are nursing staff shortages within the Killead ward.
4. Unacceptable noise levels in the ward and the mix of patients being treated.
5. Increase in the number of incidents on the ward.
6. Lack of activities for patients.

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

- Discussion with staff and managers.
- Discussions with patients.
- Examination of records.
- File audit.
- Evaluation of findings and
- Feedback.

Any other information received by RQIA about this service and the service delivery was also considered by inspectors in preparing for this inspection.

Inspectors met with five patients, five nursing staff, the deputy ward manager, two consultant psychiatrists, the psychiatric intensive care unit (PICU) ward manager, the clinical nurse lead and the hospital services manager. Inspectors met with the ward's management team and informed them of the nature of the allegations that had been received by RQIA.

Inspectors noted that patients on the ward presented as being at ease in their surroundings and were actively engaging with ward staff. The ward was busy, although the atmosphere remained calm and relaxed. Patients who met with inspectors reported no concerns regarding their care

and treatment. Patients were complimentary regarding the ward's environment and stated that relationships with staff were good.

The presenting needs of patients on the ward often resulted in the need for staff to undertake continuous one to one observation with patients assessed as requiring this level of support. Subsequently, staffing requirements remained under continued review and were subject to regular change. At the time of the inspection three patients were receiving one to one and two to one observations requiring the continued support of four staff. Staff levels included 11 nursing staff available during the am and pm shifts with five staff at night.

Inspectors evidenced that the transfer of patients from Cranfield female ward to Killead had caused disruption and presented a number of challenges for patients and staff. Patients informed inspectors that they felt the move to Killead had been positive. Patients stated that they enjoyed the space within Killead and the bigger bedrooms. Staff stated that the move had been completed at short notice and with limited preparation.

Inspectors evidenced that the ward had experienced nursing staff shortages during the first four weeks after the move. Staff stated that bank and agency nursing staff were used to meet the shortfalls. The ward's senior management team had taken appropriate steps to address nursing staff deficits and a number of new nursing staff had since been appointed. Inspection findings evidenced one area requiring improvement. This related to the arrangements in place to ensure that staff are involved in and notified off proposed moves/changes to ward environments in a timely manner. Staff informed inspectors that they had been given four days' notice. This was insufficient notification to allow staff to appropriately prepare patients and the required logistics.

Whilst the move from Cranfield female to Killead had resulted in significant disruption for patients and staff inspectors found no evidence to substantiate the allegations presented to RQIA.

4.1 Inspection Outcome

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

Allegation 1 - Causal links between the deterioration in a patient's health and the transfer of patients from Cranfield ward to Killead.

Based on the evidence available to inspectors, on the day of the inspection, the allegation that a patient's health deteriorated as a result of patients transferring from Cranfield female ward to Killead could not be substantiated. Patients stated that they had no concerns regarding the Killead ward and that the move to Killead had been positive. Patients told inspectors that they were content within the ward's environment and that the bedrooms were furnished and fitted to a good standard.

Inspectors reviewed three sets of patient care records including the records of the patient whose health had allegedly deteriorated. Inspectors found no conclusive evidence to support the assertion that the patient had deteriorated as a direct result of having to move from Cranfield female ward to Killead.

Allegation 2 - Killead Environment was Overcrowded

On the day of the inspection there were 18 patients admitted to the ward. The ward can accommodate 21 patients. Inspectors found no evidence to support the allegation that the ward was overcrowded. Each patient had their own bedroom and two patients could available of self-contained apartments with separate entrances. The ward's main areas were clutter free, clean and appropriately maintained. There was sufficient seating for both patients and staff and patients could access the ward's large garden area as required.

Allegation 3 - Staffing Levels

Staffing levels on the ward were discussed with patients, nursing staff, and medical staff and with the ward's senior managers. Patients reported no concerns regarding staffing levels. Staff stated that during the transition period, and the subsequent four weeks, the ward had experienced nursing staff shortages. Inspectors were informed that staffing levels were severely stretched during this period. A combination of moving to a bigger ward with increased patient numbers, staff on leave and the short notice with which the transfer had commenced resulted in a number of shifts not having a full complement of permanent nursing staff. Inspectors were informed that this was addressed by the senior management team through increased use of bank and agency staff and the ongoing recruitment of nursing staff. Staff stated that the staff levels on the ward were now at full complement with a number of new nurses having recently commenced posts. Whilst inspectors found no evidence to support the allegation that the ward was currently short staffed. Inspectors were concerned that the timing and notice given prior to the transfer was insufficient to prepare patients, the staff team and to ensure adequate staffing levels. This issue is discussed in the provider compliance plan at the end of this report.

The allegation that Killead is short staffed was not substantiated during the inspection.

Allegation 4 - Unacceptable noise level on the ward and the mix of patients being treated

The Killead ward provides care and treatment to patients who have a learning disability and are experiencing an acute mental health problem. Subsequently, patients admitted to the ward can present as unwell. Inspectors evidenced that the ward was providing care to a number of patients whose discharge from the ward had been delayed due to the unavailability of appropriate community resources. It is important to note that the Cranfield female ward provided the same care and treatment services to the same mix of patients. The greater bed capacity within Killead had resulted in the number of patients rising from15 to 18 and potentially 21.

Whilst not ideal the combination of patients no longer requiring treatment with patients who were acutely unwell was necessary, given the resource issues, to ensure the safety and wellbeing of all patients. Inspectors evidenced that the ward's senior management team continued to manage those patients whose discharge had been delayed in accordance to the required standards.

Inspectors found no evidence to support the allegation that noise levels on the ward were unacceptable. Inspectors also evidenced that patients admitted to the ward were being cared for in accordance to the ward's ethos and within the required health and social care standards.

Allegation 5 - Increase in the number of incidents on the ward

Inspectors reviewed the Trust's Datix system and the number of incidents that had taken place on Killead since July 2016. Inspectors noted that 31 safeguarding incidents had been reported. Whilst the number of reported incidents had increased it was positive to note these were being managed in accordance to regional and trust standards. Inspectors were unable to evidence that the move to Killead was directly linked to the increase in incidents. A number of other factors had to be considered including the increase in patient numbers, initial staffing level difficulties and patients adapting to their new surroundings (for example a number of incidents where reported as patients absconded from the ward because the garden fence did not provide the required level of security). Inspectors were informed that all patients who had absconded were returned to the ward without further incident. The ward's garden fence has been reassessed in accordance to the needs of the patient group.

Whilst the number of reported incidents had increased since Cranfield female ward transferred to Killead, there was no evidence to suggest that incidents had increased disproportionally when contrasted with previous incident rates in Cranfield female. However, RQIA will continue to closely monitor, through inspection processes, the level of incidents occurring in Killead.

Allegation 6 - Lack of activities for patients

Inspectors reviewed the Killead ward activity schedule. The schedule detailed activities available in the mornings, afternoon and evenings. Patients could also attend day care which was provided within the hospital site. The activity schedule evidenced that a range of activities were available to patients. This included a number of walking groups, hairdressing and beauty classes and art therapy. Inspectors were informed that the provision of activities in accordance to the timetable was not always possible due to the need for nursing staff to prioritise their duties. This included circumstances where increased numbers of patients required continuous direct support.

Inspectors found no evidence to support the allegation that there was a lack of activities available to patients in Killead.

Areas for improvement

The Trust should ensure there are robust arrangements in place when patients are being transferred within the hospital. This should include adequate notice and time to allow patients and staff to appropriately prepare.

Total number of areas for improvement	1

7.1 Areas for Improvement

This section outlines recommended actions, to address the areas for improvement identified. They promote current good practice and if adopted by the responsible person may enhance service, quality and delivery.

7.2 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 to Team.MentalHealth@rqia.org.uk for assessment by the inspector.

Provider Compliance Plan Killead	
Priority 1	
Area for Improvement No. 1 **Stated:** First time	The Trust should ensure there are robust arrangements in place when patients are being transferred within the hospital. This should include adequate notice and time to allow patients and staff to appropriately prepare.
To be completed by: Immediate and ongoing	**Response by responsible person detailing the actions taken:** The Trust will ensure there are robust arrangments in place when patients are being transferred within the hospital taking into account the reasons for the move, the urgency of the requirement for patients to move wards, and the planning time and contingency plans required to deliver this in a safe and effective manner.

Name of person completing the provider compliance plan	Esther Rafferty		
Signature of person completing the provider compliance plan		**Date completed**	09/12/2016
Name of responsible person approving the provider compliance plan	Martin Dillon		
Signature of responsible person approving the provider compliance plan		**Date approved**	09/12/2016
Name of RQIA inspector assessing response	Alan Guthrie		
Signature of RQIA inspector assessing response		**Date approved**	5 January 2017

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews