The Regulation and Quality Improvement Authority

Mental Health and Learning Disability Inpatient Inspection Report
2 – 4 October 2017

Killead Ward

Female Admissions
Muckamore Abbey Hospital
1 Abbey Road
Muckamore
Antrim, BT41 4SH

Tel No: 02895 042079

Inspectors: Wendy McGregor, Audrey McLellan, Dr B Fleming, Anne Simpson

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

Killead ward is a 20 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 relocated from Cranfield Female Ward on 4 July 2016.

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

On the days of the inspection there were 17 patients on the ward. Nine patients were detained in accordance with the Mental Health (Northern Ireland) Order 1986. There were also two patients who were on leave. Inspectors were informed that the discharge of 11 patients had been delayed due to a lack of appropriate community resources.

3.0 Service Details

Responsible person: Martin Dillon
Ward manager: Mary Bogues
Person in charge at the time of inspection: Grace Carey

4.0 Inspection Summary

An unannounced inspection took place over a period of three days on 2 – 4 October 2017.

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 Killead Ward was delivering, safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in relation to the use of restrictive practices. Patients confirmed that an explanation was given why they required a physical intervention and indicated they had been well supported and reassured following the intervention. Patients also informed inspectors that when personal items were removed from them they were given an explanation as to why the item was removed. Good practice was also found in relation to the support provided to staff. There were monthly reflective practice sessions for staff. Staff said they found these beneficial for learning and support with managing difficult situations. Medication prescriptions were completed to a good standard and medication was prescribed in accordance with British National Formulary guidelines.

Areas requiring improvement were identified during the inspection. These were in relation to the out of date ligature risk assessment, fire drills not completed in accordance with the Trust fire manual and the management of locally resolved complaints. Other areas requiring improvement were identified in relation to care documentation and the lack of clinical pharmacy support. Inspectors noted that there has been reduced staffing levels on the ward. RQIA is aware that this is an issue for the hospital site. There was evidence of ongoing active recruitment in Muckamore.

Inspectors were concerned about the management of a patient who had specific speech and language guidelines in place in relation to their eating and drinking. Ward staff addressed this issue during the inspection and also submitted their action plan to the inspector on 6 October 2017.

Inspectors met with eight patients during the inspection. Patients spoke positively about their care and treatment and were positive with their comments about the multi-disciplinary team. Patients indicated that staff treated them with dignity and respect and their privacy was maintained. Patients said they enjoyed the activities on the ward and attending day-care. However, seven out of eight patients said they sometimes do not feel safe, but also said that staff were there to support and offer them reassurance. All eight patients interviewed said the ward was noisy. Patients also said that they were frustrated about having to wait to be discharged from the ward.

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 senior trust managers, the multi-disciplinary team and ward staff as part of the inspection process. Findings from the report can be found in the main body of the report.

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 or 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 inspectors met with eight patients, seven members of the multi-disciplinary team and two advocates. There were no relatives available to meet with inspectors during the inspection.

A lay assessor was present during the inspection and their comments are included within this report.

The following areas were examined during the inspection:

- Care documentation in relation to five patients.
- Care documentation audits.
- Staff rota.
- Training records.
- Staff meetings.
- Patient forum meetings.
- Patient experience audits.
- Medication prescription records.
- Patient finances.
- Ward welcome pack.
- Staff induction records.
- Informal complaints.
- Fire safety records.
- The ward physical environment.

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

We reviewed the area for improvement made at the last inspection in relation to noise levels on the ward. An assessment of compliance was recorded not met.

6.0 The Inspection

6.1 Review of Areas for Improvement / Recommendations from the Most Recent Inspection dated 14 - 15 February 2017

The most recent inspection of Killead Ward was an unannounced inspection. The completed provider compliance plan was returned and approved by the

responsible inspector. This provider compliance plan was validated by the responsible inspector during this inspection.

6.2 Review of Areas for Improvement / Recommendations from Last Inspection dated 14 to 15 February 2017

<table>
<tr><th colspan="2">Areas for Improvement</th><th>Validation of Compliance</th></tr>
<tr><td rowspan="2">Area for Improvement No. 1

Ref: Quality Standard 6.3.1 (c)

Stated: First Time</td><td>When a number of patients are in the main communal area/dining room the noise levels appear to echo and reverberate which can be distracting and unpleasant for patients in this room.</td><td rowspan="2">Not Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
Inspectors observed high levels of noise during the three days of the inspection. This was also further impacted by the complex behavioural and mental health needs of patients on the ward. Some patients were presenting as very vocal. There were also patients who were at different stages of admission including 11 patients whose discharge was delayed. The NICE Guidelines Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges May 2015 states that environments with too much sensory stimulation can increase the risk of challenging behaviours. Inspectors noted that there were a high number of recorded incidents caused by challenging behaviours on the ward. Inspectors were informed that one patient was transferred to the hospital's Psychiatric Intensive Care Unit (PICU) because of the high volume of noise and the impact that this was having on patient behaviours.
All of the eight patients interviewed said the ward was noisy and some said that is was noisy at night.

Inspectors were informed that the trust have been in contact with a company</td></tr>
</table>

	called Ecophon. Two staff from Ecophon have attended the ward and assessed the acoustics and measurements and cost etc. The trust is waiting on formalised quotation from company. This area for improvement will be restated a second time.	

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

Patients were involved in their risk assessments and risk management plans.

Risk assessments and management plans informed patients' care plans.

Safeguarding vulnerable adult referrals and follow up action plans had been completed in accordance with Regional Safeguarding Policy. There were appropriate safety plans in place where required.

With the exception of the ligature risk assessment, all other environmental risk assessments were up to date.

Each patient who required a profiling bed had a care plan in place.

The ward environment was clean and tidy.

There were daily safety briefings which included all staff working on the ward.

Staff raised any concerns they had in relation to patient and/or environmental safety with their line manager.

Staff followed trust policy and procedure in relation to the management of incidents and the use of restrictive practices.

Staff stated they did not work beyond their role and experience.

Staff were observed to manage the patient dynamic very well given the complex range of needs of the patients. Staff were observed responding

quickly and effectively to incidents. Staff were observed to be present in the communal areas at all times during the inspection.

Patients who were detained in accordance with the Mental Health (Northern Ireland) Order 1986 had been appropriately referred to the Mental Health Review Tribunal.

Capacity for consent for different care interventions was recorded and staff were knowledgeable on each patient's capacity to consent, how consent was obtained and how a patient indicates their capacity to consent. Patients also indicated that staff sought consent.

Areas for Improvement

Inspectors were concerned about the management of patients who have specific speech and language guidelines in place in relation to their eating and drinking.

The ligature risk assessment was out of date and did not include the four profiling beds and the ligature risk identified in the TV room.

There was evidence of one walk/talk through fire drill involving eight staff and 12 patients on 5 March 2017. This was not in accordance with the Trust fire manual which states "There should be an annual program of fire drills designed so that every member of staff has the opportunity to participate in at least one."

A record of locally resolved complaints was maintained on the ward. This record did not include the outcome of complaints.

Number of areas for improvement	4

7.2 Is Care Effective?

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

Areas of Good Practice

All assessments, care plans and progress notes were consistently recorded on the patient electronic recording system (PARIS).

Each patient had a comprehensive, person centred assessment in place.

Multi-disciplinary team case notes were detailed and person centred.

Patients who were assessed as requiring care and treatment were reviewed every week by the multi-disciplinary team (MDT) and patients whose

discharge was delayed were reviewed every two weeks by the MDT. The minutes of the review evidenced a holistic patient centred approach. Patients were offered the opportunity to attend their meetings.

There was a comprehensive record of the 1:1 meetings between each patient and their named/associate nurse.

Patients could access a range of care and treatment options.

The use of restrictive practices was clearly documented and reviewed frequently. There was evidence of review of practices such as enhanced observations and reduction following review.

Areas for Improvement

There were duplications of care plans. This was confusing and unnecessary. For example one patient had five copies of a care plan and another patient had seven care plans, in place in relation to similar behaviours, with the same interventions recorded. The date the care plans were written or the author was not recorded. There was an inconsistent approach to reviewing care plans.

Patient care documentation was audited however the name of the auditor and date was not always recorded. It was also unclear if the deficiencies identified in the care documentation had been addressed.

Number of areas for improvement	2

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

Patients stated they were treated with dignity and their privacy is respected.

Staff were observed throughout the period of the inspection to respond compassionately to patients who were physically and / or emotionally distressed.

Inspectors and the lay assessor observed staff treating patients with dignity and respect and were compassionate toward patients. Staff were also observed making every effort to maintain a calm environment.

Patients confirmed they were offered the opportunity to attend meetings about their care, treatment and discharge plans.

There was a range of easy to read information available to assist patient to make informed choices.

The use of restrictive practices was explained to patients.

Advocacy services were available to patients and relatives. Advocates confirmed they attended meetings in relation to resettlement.

Areas for Improvement

No areas for improvement in relation to compassionate care 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

Staff from the multi-disciplinary team said they were well supported and that there was a good working relationship between the team.

There were systems in place to analyse risks, accidents, incidents, complaints, safeguarding referrals, and the effectiveness of protection plans, staff disciplinary matters, whistleblowing and mortality rates. There was a focus on learning when things go wrong. Learning was shared with all relevant staff.

Patient forum meetings were held every month. Areas for action were identified and addressed. There was a person centred approach to patients' views of their care and treatment.

A patient satisfaction survey was completed in September 2017. Findings from the survey were positive and were displayed on the ward.

Good attendance was noted at the monthly staff meetings. Relevant information was discussed at the meetings such as any new processes. It was noted that staff were commended for their work at staff meetings.

There was good attendance noted at the monthly reflective practice sessions. A good range of issues were discussed such as managing Absence Without Leave (AWOL), managing allegations against staff, managing aggression,

working with patients who have safety plans, staff morale and the impact of RQIA and educational audits and delayed discharges.

Overall feedback from the multi-disciplinary team was positive about their role on the ward.

Areas for Improvement

There was no regular clinical pharmacy support to the ward.

Number of areas for improvement	1

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 24 November 2017.

Provider Compliance Plan Killead Ward	
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:** 6 October 2017	Inspectors were concerned about the management of patients who have specific speech and language guidelines in place in relation to their eating and drinking.
	Response by responsible person detailing the actions taken: In response to this area of improvement, ward staff addressed the particular issue (in relation to one patient), highlighted during the inspection and submitted an action plan to RQIA on 6th October. Other patients on the ward who have specific speech and language guidelines in place in relation to their eating and drinking have had a referral to Speech & Language Therapy and a personal place mat developed. This is reflected in their nursing assessment and plan of care.
Area for Improvement No. 2 **Ref: Quality Standard 5.3.1 (f)** **Stated:** First time **To be completed by:** 6 November 2017	The ligature risk assessment was out of date.
	Response by responsible person detailing the actions taken: In response to this area of improvement, the up to date ligature Risk Assessment is available in the Ward, this was been updated in August 2017 for the incoming year and includes the four profiling beds and the ligature risk identified in the TV room.
Area for Improvement No. 3 **Ref: Quality Standard 8.3 (k)** **Stated:** First time	The record of locally managed complaints did not include an outcome of the complaints.
	Response by responsible person detailing the actions taken: In response to this area of improvement, locally managed complaints now include an outcome of the complaint; this is

To be completed by: 6 November 2017	recorded on the Trust complaint record form.
Priority 2	
Area for Improvement No. 4 **Ref:** Quality Standard 5.3.1(e) **Stated:** First time **To be completed by:** 12 January 2018	Fire drills were not completed in accordance with the Trust's fire manual.
	Response by responsible person detailing the actions taken: In response to this area of improvement, a walk/talk fire drill and an evacuation were completed on 8th and 22nd November. The ward management team have devised a template to facilitate fire drills to ensure every member of staff has the opportunity to participate in at least one
Priority 3	
Area for Improvement No. 5 **Ref:** Quality Standard 6.3.1 (c) **Stated:** Second time **To be completed by:** 4 April 2018	When a number of patients are in the main communal area/dining room the noise levels appear to echo and reverberate which can be distracting and unpleasant for patients in this room.
	Response by responsible person detailing the actions taken: In response to this area of improvement, costs have been confirmed from the supplier and a bid has been submitted to the capital evaluation team as a prioritised bid.
Area for Improvement No. 6 **Ref:** Quality Standard 5.3.1 (a) **Stated:** First time **To be completed by:** 4 February 2018	There were duplications of care plans. The date that the care plans were written and the author was not recorded. There was an inconsistent approach to reviewing care plans.
	Response by responsible person detailing the actions taken: In response to this area of improvement, training is ongoing with registrants in relation to care planning. Duplicate plans of care are closed. All assessments and plans of care are signed, date and time stamped on completion.

Area for Improvement No. 7 **Ref:** Quality Standard 5.3.1 (a) **Stated:** First time **To be completed by:** 4 April 2018	There was no regular clinical pharmacy support to the ward. **Response by responsible person detailing the actions taken:** The hospital has pharmacy support from the Trust pharmacy department. There is no dedicated pharmacy for Muckamore and currently no funding for this. The trust will discuss clinical pharmacy support with HSCB to highlight this area of improvement.

Name of person(s) completing the provider compliance plan	Oonagh McMackin		
Signature of person(s) completing the provider compliance plan	Oonagh McMackin	**Date completed**	November 17
Name of responsible person approving the provider compliance plan	Mairead Mitchell		
Signature of responsible person approving the provider compliance plan	Mairead Mitchell	**Date approved**	November 17
Name of RQIA inspector assessing response	Wendy McGregor		
Signature of RQIA inspector assessing response	Wendy McGregor	**Date approved**	27 November 2017

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