

Unannounced Inspection Report 14-15 February 2017



Killead

Type of service: Female admissions ward

Address: Muckamore Abbey Hospital

1 Abbey Road

Muckamore

Antrim BT41 4SH

Tel No: 028 95042079

Inspectors: Audrey McLellan and Cairn Magill

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

Killead ward is a 24 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 advocacy services were also available.

On the days of the inspection there were 19 patients on the ward and one patient on leave. Two patients were accommodated in individual areas within the ward. Inspectors were informed that the discharge of 10 patients had been delayed due to a lack of appropriate community resources.

3.0 Service details

Responsible person: Martin Dillon	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 14-15 February 2017.

The inspection was undertaken in response to concerns received by RQIA from two callers. The concerns raised related to the following allegations:

1. Increase in the number of incidents on the ward since the ward moved from Cranfield in July 2016.
2. Staff shortages within the Killead ward.
3. Unacceptable noise levels in the main communal area of the ward.

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

- Discussions with nursing staff and managers.
- Discussions with the Designate Officer (responsible social worker) for investigating all safeguarding incidents.
- Discussions with patients.
- Examination of incidents on Killead ward and Cranfield ward which included incidents of;
 - Physical intervention
 - Rapid tranquilisation
 - Use of seclusion
 - Safeguarding incidents
- Observation of the ward environment.
- Observation of interactions between staff and patients

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 four patients, three nursing staff, the social worker, the ward manager and the clinical and therapeutic services manager.

On arrival to the ward the inspectors met with the ward manager to inform them of the nature of the allegations which had been received by RQIA.

All four patients who met with the inspectors stated they were happy on the ward and confirmed the move from Cranfield ward was positive as the Killead ward is bigger therefore they have more space on this ward. All four patients spoke positively about the ward, the staff and the care and treatment they were receiving. They described the many activities they take part in each week many of which were off the ward in the day centre and in the local community.

Although the ward was busy the atmosphere remained calm and relaxed. The inspectors observed a number of behaviours displayed by patients on the ward which could have resulted in incidents occurring. However, all incidents were managed by staff in a very skillful manner. Staff were observed using diversional techniques to ensure patients were unharmed. Inspectors found that whilst the move from Cranfield Female ward to Killead ward had resulted in an initial rise in some incidents these had now reduced to the level they were at prior to the move.

At the time of the inspection there were three patients receiving enhanced observations. Two patients were on 1:1 observations and one patient was on 2:1 observations. Staffing levels on the day of the inspection included seven health care assistants and four staff nurses. Staff on the night shift included two staff nurses and three health care assistants. The inspectors reviewed the staffing levels over a period of time and there was evidence of a high use of bank staff and on occasions the ward did not have the required level of staff. However, this was discussed with senior managers at the conclusion of the inspection and it was confirmed that there are plans in place to recruit new staff to the ward.

Inspectors observed that when patients were in the large communal room of the ward the noise appeared to vibrate through this room due to the high ceiling and limited furnishings. This was observed as very distracting and unpleasant for patients in this room. An area of improvement has been made in relation this.

4.1 Inspection outcome

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

Allegation 1 - Increase in the number of incidents on the ward

The inspectors reviewed the number of incidents that had taken place in Killead since July 2016 and compared this to the number of incidents for the previous six months when the patients were in the Cranfield ward. The inspectors found that the number of reported incidents involving patients and staff had decreased. However, the number of incidents involving patients with other patients had increased initially although over the six month period this had started to decrease. There was evidence to suggest that the move to the new ward had contributed to the initial rise in incidents however as patients have begun to settle into this new environment the incidents are now decreasing and are at the same level prior to the move to Killead.

When inspectors spoke to staff it became apparent that there had been a number of incidents on the ward involving more than two patients. There was evidence that the ward staff had

reflected on each of these incidents to try and ensure incidents of this nature are prevented in the future. The ward manager has set up regular reflective practice meetings with staff and the clinical psychologist to discuss individual patients and how best to manage incidents when they arise. Although it is important to note that these incidents were managed appropriately by staff and all staff who spoke to the inspectors stated they were well supported when incidents occurred on the ward.

The number of incidents involving the use of physical intervention had decreased over the past six months and the number of safeguarding incidents had not significantly changed. Overall there was no evidence to suggest that incidents apart from the incidents involving patients with other patients had increased disproportionately when contrasted with previous incident rates in Cranfield Female ward. However, RQIA will continue to monitor all incidents on the ward through the inspection process.

Allegation 2 – Staff shortages

Staffing levels on the ward were discussed with patients, nursing staff, and the ward manager and with the ward's senior managers. Patients reported no concerns regarding staffing levels. Staff stated that there are times when they have to try and contact staff on the bank system to cover shifts and on occasions they had to stay late to cover shifts. The inspectors reviewed the staffing rota and there was evidence that the ward was using bank staff on a regular basis to cover shifts and on a number of occasions the staffing levels were below the required level. This issue was discussed with the ward manager and senior managers who advised that a number of staff have left their posts due to retirement and promotion into other posts and there are a number of nurses on extended leave. They stated they have recruited three new staff nurses and have a rolling recruitment in place at present. They are in the process of interviewing new health care assistants which should reduce the use of bank staff on the ward. They advised the main staffing issue is retaining staff on the overall hospital site as many move on to new posts in the community. They also advised they have highlighted the way forward regarding this issue in a paper to the Director of Nursing in the trust.

The allegation that Killead is short staffed was substantiated on some occasions on the ward. However, this only occurs when all other processes have been exhausted. For example when no one can cover from the bank system or from other wards on the hospital site. However, the trust have recognised this as an area of concern and are in the process of recruiting new staff and have highlighted concerns regarding retaining staff to the Director of Nursing within the trust.

Allegation 3 - Unacceptable noise levels in the communal area of the ward

The Killead ward provides care and treatment to patients who have a learning disability and are experiencing an acute mental health problem. Unfortunately there are also 10 patients on the ward whose discharge from the ward has been delayed due to the unavailability of appropriate community resources and therefore they are not receiving active care and treatment. It is not an ideal situation caring for patients who no longer require care and treatment in a hospital site and caring for patients who were acutely unwell. RQIA have highlighted this issue to the HSCB on a number of occasions in the past.

The ward is a much larger environment than Cranfield Female ward was and therefore there is greater bed capacity which has resulted in the number of patients rising from 15 to 19 with the potential for 24 patients to be accommodated.

Inspectors observed that when patients are in the dining room/communal area the noise echoes throughout the ward and creates a noise reverberation which can be very distracting and unpleasant. The ward staff have tried to encourage patients to access other parts of the ward as there are a number of rooms the patients can avail of which are very pleasant. However, patients tend to congregate in this large open area as the nurses' station is in this room and it appears to be the hub of the ward. As the dining room is also in this large space staff have to manage meals times in this environment on a daily basis. Patients with hearing impairments, sensory problems and autism may find this area very distressing due to the high ceiling creating vibrating sounds.

Concerns regarding this room were discussed with senior managers who advised that they are in the process of looking at ways to reduce the noise levels in this room. One option is to reduce the height of the ceiling and to add soft furnishings to the room and another option is noise reducing 'buffers' which hang from the ceiling. Senior managers stated they will seek expert opinions in relation to the best way forward to improve the ward environment for patients.

The allegation regarding the noise levels being unacceptable in the communal area of the ward was substantiated. However, it was good to note the senior managers are already in the process of trying to make this area more pleasant for patients to utilise on the ward. An area of improvement has been made in relation to this allegation.

Areas for improvement

1. 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.

Total number of areas for improvement	1
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5.0 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.

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

Provider Compliance Plan Killead	
Priority 1	
Area for Improvement No. 1	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.
Standard:	
Stated: First time	Response by responsible person detailing the actions taken: In response to this area for improvement, hospital management are researching options to decrease the noise level.
To be completed by: 15 August 2017	

Name of person completing the provider compliance plan	Mary Bogue		
Signature of person completing the provider compliance plan		Date completed	20 th March 2017
Name of responsible person approving the provider compliance plan	Martin Dillon		
Signature of responsible person approving the provider compliance plan		Date approved	23 rd March 2017
Name of RQIA inspector assessing response	Audrey McLellan		
Signature of RQIA inspector assessing response		Date approved	7 April 2017



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