The Regulation and Quality Improvement Authority

Moylena

Muckamore Abbey Hospital

Belfast Health and Social Care Trust

Unannounced Inspection Report

Date of inspection: 18 November 2015

npm national preventive mechanism

Ward address: Moylena

Muckamore Abbey Hospital

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Our Vision, Purpose and Values

Vision

To be a driving force for improvement in the quality of health and social care in Northern Ireland

Purpose

The Regulation and Quality Improvement Authority (RQIA) is the independent health and social care regulator in Northern Ireland. We provide assurance about the quality of care, challenge poor practice, promote improvement, safeguard the rights of service users and inform the public through the publication of our reports.

Values

RQIA has a shared set of values that define our culture, and capture what we do when we are at our best:

- **Independence** - upholding our independence as a regulator
- **Inclusiveness** - promoting public involvement and building effective partnerships - internally and externally
- **Integrity** - being honest, open, fair and transparent in all our dealings with our stakeholders
- **Accountability** - being accountable and taking responsibility for our actions
- **Professionalism** - providing professional, effective and efficient services in all aspects of our work - internally and externally
- **Effectiveness** - being an effective and progressive regulator - forward-facing, outward-looking and constantly seeking to develop and improve our services

This comes together in RQIA's Culture Charter, which sets out the behaviours that are expected when employees are living our values in their everyday work.

Contents

1.0 Introduction

The Regulation and Quality Improvement Authority (RQIA) is the independent health and social care regulator in Northern Ireland. We provide assurance about the quality of care, challenge poor practice, promote improvement, safeguard the rights of service users and inform the public through the publication of our reports.

RQIA's programmes of inspection, review and monitoring of mental health legislation focus on three specific and important questions:

Is Care Safe?

- Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them

Is Care Effective?

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

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

2.0 Purpose and Aim of this Inspection

To review the ward's progress in relation to recommendations made following previous inspections.

To review the ward's progress in relation to learning identified following a significant event audit.

2.1 What happens on inspection

What did the inspector do:

- reviewed the quality improvement plan sent to RQIA by the Trust following the last inspection(s)
- reviewed different types of documentation

At the end of the inspection the inspector:

- discussed the inspection findings with staff

- agreed any improvements that are required

After the inspection the ward staff will:

- send an improvement plan to RQIA to describe the actions they will take to make any necessary improvements

3.0 About the ward

Moylena is a resettlement ward that provides continuing care to eight male patients with a learning disability who present with behaviours that challenge. All patients on Moylena ward are waiting discharge into community facilities.

There were eight patients on the ward on the day of the inspection. One patient on the ward was detained in accordance with the Mental Health (Northern Ireland) Order 1986.

Patients on the ward have access to a multi-disciplinary team consisting of nursing and psychiatry. Access to speech and language therapy, occupational therapy, behaviour support, clinical psychology is by referral. Independent advocacy services were available. The person in charge on the days of the inspection was the deputy ward sister.

4.0 Summary

Progress in implementing the recommendations made following the previous inspection carried out on 20 & 21 May 2015 were assessed during this inspection. There were a total of eleven recommendations made following the last inspection.

It was good to note that all recommendations had been implemented in full.

4.1 Implementation of Recommendations

Six recommendations which relate to the key question "**Is Care Safe**?" were made following the inspection undertaken on 20 & 21 May 2015.

These recommendations concerned safeguarding vulnerable adults, restrictive practices, risk assessments and the use of the patient electronic care recording system (PARIS).

The inspector was pleased to note that all of the recommendations had been fully implemented:

- Staff had considered and implemented safeguarding vulnerable adults procedures in the event that patients had sustained or presented with unexplained marks and bruises;

- The ward sister had evaluated all restrictive practices in use on the ward in relation to their impact on all patients and patient's individual rights to ensure the needs of other patients were not compromised;

- Restrictive practices had been reviewed by the ward team and senior management. The ward sister had introduced a strategy to reduce the level of restriction on the ward;

- Patients / and their relatives had been involved in the risk screening tool and a rationale was recorded when this was not possible;

- Care plans in relation to restrictive practices had been reviewed and the rationale for the restriction was based on individual risk assessments. Deprivation of liberty was noted to be proportionate and necessary to each identified risk;

- Patients care records had been uploaded onto the patient electronic care recording system (PARIS);

Three recommendations which relate to the key question "**Is Care Effective**?" were made following the inspection undertaken on 20 & 21 May 2015.

These recommendations concerned communication assessments, support with communication and behaviour assessments and management plans.

The inspector was pleased to note that all of the recommendations had been fully implemented:

- Speech and language support had increased on the ward. Each patient had an assessment of their communication completed by the speech and language therapist;

- An individualised communication tool had been developed and implemented for each patient;

- Behavioural assessments had been completed by either nursing staff on the ward or the behaviour support team. Behaviour management plans were in place to support patients who present with behaviours that challenge;

Two recommendations which relate to the key question "**Is Care Compassionate**?" were made following the inspection undertaken on 20 & 21 May 2015.

These recommendations concerned blanket restrictions, patient privacy.

The inspector was pleased to note that both recommendations had been fully implemented:

- The trust had reviewed the blanket restriction of locked internal doors in the ward;
- All damaged coverings on bathroom doors had been replaced;

4.2 Serious Adverse Incident Investigation

A significant event audit was completed following a safeguarding vulnerable adult incident on this ward on 25 April 2014. The inspector reviewed the Trust's progress in addressing recommendations made related to ward practices following the Trust's report of the significant event audit.

The safeguarding vulnerable adult policies and procedures had been revisited by the designated officer in relation to the prompt reporting of safeguarding vulnerable adult concerns.

5.0 Other areas examined

The inspector reviewed the care documentation in relation to two patients who were using the profiling beds. The inspector noted a risk assessment and care plan had not been completed in relation to ligature risks associated with the use of profiling beds. A recommendation has been made.

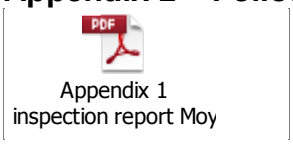
6.0 Next Steps

A Quality Improvement Plan (QIP) which details the areas identified for improvement has been sent to the ward. The Trust, in conjunction with ward staff, must complete the QIP detailing the actions to be taken to address the areas identified and return the QIP to RQIA by **12 January 2016**.

The lead inspector will review the QIP. When the lead inspector is satisfied with actions detailed in the QIP it will be published alongside the inspection report on the RQIA website.

The progress made by the ward in implementing the agreed actions will be evaluated at a future inspection.

Appendix 1 – Follow up on Previous Recommendations



Appendix 1

Follow-up on recommendations made following the announced inspection on 20 and 21 May 2015

No.	Reference.	Recommendations	Number of time stated	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	5.3.1 (c)	It is recommended that existing ward protocols are developed to ensure that staff consider implementation of the safeguarding vulnerable adults procedures in the event of a patient sustaining or presenting with unexplained marks, bruises etc.	3	The inspector spoke with the designated officer who stated that they had no concerns. The designated officer also confirmed that staff on the ward adhere to the safeguarding vulnerable adult policy and procedures. The designated officer stated staff had contacted them when patients sustain or present with unexplained marks or bruises. A decision was agreed between staff and the designated officer if a safeguarding vulnerable adult referral was required. The inspector noted discussions with the designated officer were recorded in patients care documentation. The inspector reviewed body charts completed for three patients and noted that these had been fully completed. Where body charts had been completed by a heath care assistant, the chart had been checked and signed by a registered nurse.	Met
2	5.3.1.(a)	It is recommended that the ward manager ensures that all restrictive practices in use on the ward are evaluated in relation to their impact on all patients and that individual patients' rights are not compromised by the needs of	3	The inspector observed the ward environment and noted improvements had been made. All internal doors were now open. The inspector reviewed care documentation and noted that restrictive practices were individually reviewed.	Met

		other patients.		Individual restrictive practices were also reviewed at each patient's monthly multi-disciplinary meeting.	
3	5.3.1 (b)	It is recommended that the ward manager ensures that patients and or their representatives are involved in the risk screening tool, and a clear rationale is recorded when this is not possible.	2	The inspector reviewed Promoting Quality Care risk screening tools completed for three patients. A rationale was recorded when patients were not involved in their risk screening tools. There was evidence that patient's representatives were involved in the three risk screening tools reviewed.	Met
4	5.3.1 (a)	It is recommended the ward manager ensures that care plans in relation to restrictive practices are reviewed to ensure that the rationale is based on individual risk assessments and to ensure the deprivation of liberty is proportionate and necessary to each identified risk.	2	The inspector reviewed care documentation in relation to three patients. The inspector noted an individualised restrictive practice care plan was in place. The restriction was based on each patient's individualised risk and evidenced that deprivation of liberty was proportionate and necessary to each identified risk.	Met
5	5.3.3 (b)	It is recommended that the Trust reviews restrictive practices on the ward. This review should include the introduction of strategies to reduce the level of restriction to help prepare patients for a successful transition into the community.	2	The inspector reviewed the ward environment and noted that all internal doors were now open. The inspector reviewed care documentation in relation to three patients. A review of restrictive practices had been completed for each patient. Strategies were in place to work towards reducing the level of restriction for each patient in order to help patients prepare for a successful transition into the community.	Met
6	5.3.1 (a)	It is recommended that the trust ensures that patients' records	1	The inspector reviewed the electronic care recording system (PARIS) for three	Met

		have been uploaded onto the electronic care record system (PARIS). A system should be introduced for records that cannot be uploaded on to the PARIS system.		patients. All records that could be uploaded were available on the PARIS system. A system was introduced for records that could not be uploaded onto the PARIS system. Each patient had one hard copy file with the following contents; • Paper correspondence, letters, appointments; • Body charts that were not part of a safeguarding vulnerable adults referral; • Modified Early Warning Score (MEWS) charts; • Medication recording sheets; • Blood and laboratory results; • Care plan audit;	
7	5.3.1 (a)	It is recommended that the ward manager ensures that all patients who require support with communication have a communication assessment completed.	2	The inspector was informed by the deputy ward sister that all patients had an assessment of their communication completed by the speech and language therapist. The inspector reviewed care documentation in relation to three patients and noted that each patient had a communication assessment completed by speech and language therapy. Each patient also had a nursing assessment and care plan completed in relation to communication.	Met
8	5.3.3 (a)	It is recommended that the ward manager ensures that following a communication assessment, a	2	The inspector was informed by the deputy ward sister that each patient had an individualised communication system in	Met

		communication tool is developed and implemented to support patients with their communication.		place. This was confirmed by the inspector. In addition to the communication passport the inspector noted that each patient had an individualised communication system in place. The following individualised communication systems were noted to be in place; visual aids, symbols, and pictures, and pictorial scheduling. The inspector noted that the communication systems were incorporated into the nursing care plans in the three sets of care documentation reviewed.	
9	5.3.1 (a)	It is recommended that the ward manager ensures that patients who present with behaviours that challenge have a behaviour assessment completed and following this an appropriate behaviour management plan is developed and implemented.	1	The inspector reviewed care documentation in relation to three patients. Each patient had an assessment and care / management plan completed by nursing staff in relation to behaviours that challenge. The inspector spoke to the behaviour nurse specialist, who stated that when required patients can be referred to them. The behaviour management team were supporting one patient in Moylena. The behaviour nurse specialist stated that not all patients require input from their team as patients can be supported through nursing care plans. However, they were available for consultation. The behaviour nurse specialist informed the inspector that the behaviour team had increased to include two band 7 and three	Met

				band 6 behaviour nurse specialists.	
10	5.3.1 (a)	It is recommended the Trust reviews the blanket restriction of locked internal doors within Moylena.	2	The trust has reviewed the blanket restriction of the locked internal doors. The inspector reviewed the ward environment and noted that all internal doors were open.	Met
11	6.3.2 (a)	It is recommended that the ward manager ensures the frosted covering on the bathroom door 57 sufficiently affords patients privacy and dignity.	1	The inspector reviewed the ward environment and noted that all bathroom doors had frosted covering. This ensured patients had privacy and their dignity was respected.	Met

Quality Improvement Plan

Unannounced Inspection

Moylena, Muckamore Abbey Hospital

18 November 2015

The areas where the service needs to improve, as identified during this inspection visit, are detailed in the inspection report and Quality Improvement Plan.

The specific actions set out in the Quality Improvement Plan were discussed with the deputy ward sister, consultant psychiatrist, hospital services manager, resettlement officer, adult safeguarding officer, resource nurse and business manager on the day of the inspection visit.

It is the responsibility of the Trust to ensure that all requirements and recommendations contained within the Quality Improvement Plan are addressed within the specified timescales.

Recommendations are made in accordance with The Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS, 2006.

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
Is Care Safe?					
1	5.3.1 (a)	It is recommended that the ward sister ensures that patients who require a profiling bed have a ligature risk assessment and management plan completed in accordance with Estates and Facilities Alert (EFA) Ref: EFA/2010/006 Issued: 6 June 2010.	1	18 January 2016	At present there are two patients in Moylena who sleep in a profiling bed. The reasons and associated risks are now documented and managed through the patients care plan in accordance with Estates and Facilities Alert (EFA) Ref: EFA/2010/006 Issued: 6 June 2010.
Is Care Effective?					
No recommendations					
Is Care Compassionate?					
No Recommendations					

Recommendations are made in accordance with The Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS, 2006.

NAME OF WARD MANAGER COMPLETING QIP	Mary Bogue
NAME OF CHIEF EXECUTIVE / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Martin Dillon

Inspector assessment of returned QIP		**Yes**	**No**	**Inspector**	**Date**
A.	Quality Improvement Plan response assessed by inspector as acceptable	✓		Wendy McGregor	**24 December 2015**
B.	Further information requested from provider				