Mental Health and Learning Disability Inpatient Inspection Report
5 and 6 June 2018

Gillis Memory Centre
Dementia Care
St. Luke's Hospital
Loughgall Road
Armagh
BT61 7NQ

Tel No: 028 3741 2183
Inspectors: Alan Guthrie, Dr John 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

Gillis Memory Centre is a 24 bedded mixed gender ward. The ward provides assessment and treatment to patients who have a diagnosis of dementia or have a presentation suggesting dementia with associated behaviours that are challenging. On the day of the inspection there were 22 patients on the ward including one patient who was admitted to an acute general hospital. There was one patient detained in accordance with the Mental Health (Northern Ireland) Order 1986. The multi-disciplinary team (MDT) included three consultant psychiatrists, a staff grade doctor, nursing staff, an occupational therapist, a social worker and a dementia care activity coordinator. A patient

advocacy service was also available. The ward manager was in charge on the day of the inspection.

3.0 Service Details

Responsible person: Shane Devlin
Ward manager: Sally Kennedy
Person in charge at the time of inspection: Sally Kennedy

4.0 Inspection Summary

An unannounced inspection took place over two days on 5 and 6 June 2018.

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 the Gillis 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 ward provided patient centred care.
- The MDT was well led and effective.
- The ward staff had effective working relationships with community teams.
- The staff team worked well together.

Areas requiring improvement were identified. Two priority one areas for improvement have been made. The first priority one concern relates to the trust's supervision and complaints policies. This area for improvement has been restated for a third time as a result of findings from this inspection. This resulted in the ward being escalated in accordance to RQIA escalation policy and procedures. An escalation meeting was convened on the 22 June 2018. RQIA and the ward's senior management team agreed that the trust would update both policies by the 20 July 2018. The second priority one area relates to the ward's covert medication policy. The policy was available in draft form but had not been approved by the trust.

One priority two area for improvement has also been identified. This area for improvement concerns the ward's operational guidelines. The guidelines were available in draft form and required approval by the trust's executive

management team. The final area for improvement is a priority three area regarding the trust's electronic patient information system.

Patients Experience:

During the inspection inspectors met with four patients. Three of the patients were supported by an inspector to complete a questionnaire. Patients reflected positively on their experience of the ward. Patients stated that they felt the ward staff were approachable, easy to talk to and supportive. Each of the patients informed the inspector that they felt they were treated with dignity and respect. Patients also said that they had felt better since being admitted to the ward.

Throughout the inspection the atmosphere on the ward was observed to be welcoming, calm and relaxed. Staff were available throughout the ward's main areas and patient requests were responded to quickly and in an appropriate manner. Patient sleeping areas were clean, appropriately maintained and gender specific.

Patients Stated:

"I am as happy as I can be".

"There's a fair amount of staff".

"I am feeling better since I came to the ward".

"Staff listen to me".

"It's pretty good here".

During the inspection patients' relatives were invited to meet with an inspector. One of the inspectors met with a partner and two friends of one patient. The patient's partner and friends reported positively regarding their experience of the ward. They described the staff as being friendly and approachable and the quality of care provided by the ward as being good.

Staff Experience:

Inspectors met with nine members of the ward's MDT incorporating the views of clinical and support staff. Staff told inspectors that they enjoyed working on the ward and that they felt their opinion was valued and considered. Staff were complimentary regarding their experience of the MDT. The MDT was described as being inclusive, supportive and patient focussed. Staff informed inspectors that they felt the ward provided patient centred care and the care and treatment interventions were based on the presenting needs of each patient. Staff reported that they felt the interventions provided to patients were effective and based on best practice.

Inspectors met with four members of the nursing staff team. Staff presented as being motivated, knowledgeable and patient centered. Staff reported no concerns regarding their role and responsibilities. Inspectors noted that nursing staff demonstrated appropriate skills and understanding regarding the ethos of the ward and the presenting needs of patients. The ward's nursing compliment was appropriate however, inspectors evidenced that four nursing posts were vacant. The trust had undertaken recruitment to fill these posts. Inspectors reviewed the ward's nursing staff rota and noted that the ward's management team was implementing bank shifts to manage the nursing staff shortages. Inspectors were informed that bank shifts were completed by staff that were familiar with the patient group and had the required knowledge and skill. This was confirmed by nursing and MDT staff who met with inspectors on the days of the inspection.

Staff who met with inspectors stated that the ward had undergone a number of changes during the previous year. The ward had been corporately reorganised into the trust's memory service resulting in closer working relationships with the trusts three community memory teams. Ward staff had also continued to develop good working relationships with the trust's acute care at home team. Staff described these changes as having a continued positive impact for patients admitted to the ward.

Staff reported no difficulties regarding their ability to discuss any concerns they may have with the ward's senior management team. Issues regarding care practices, treatment regimens and staff relationships were discussed on a regular basis at staff team meetings and MDT meetings. Inspectors were assured by staff that issues were dealt with quickly and appropriately by the ward manager and the ward's senior management team.

Staff Stated:

"I have been really well supported."

"I have no issues regarding my training and supervision".

"I can access other training courses upon request".

"Staff are encouraged to report concerns".

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	4

Findings of the inspection were discussed with the ward's senior management team as part of the inspection process and can be found in the main body of the report.

Escalation action resulted from the findings of this inspection.

The escalation policies and procedures are available on the RQIA website. https://www.rqia.org.uk/who-we-are/corporate-documents-(1)/rqia-policies-and-procedures/

4.2 Action/enforcement taken following the most recent care inspection dated 5 and 6 June 2018.

Following this inspection a serious concerns meeting was held at RQIA on 22 June 2018 with senior trust representatives. This meeting was held to give the trust representatives the opportunity to discuss one area of improvement they had failed to improve for a third time. The outcome of the inspection and the trust's action plan to address the serious concern were also discussed.

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 the inspector met with four patients, nine members of staff and three patients' visitors/representatives.

The following records were examined during the inspection:

- Care documentation in relation to four patients.
- Staff rota.
- Training records.
- Patient medication records.
- The ward's patient admission protocols.
- Occupational therapy activity records.

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

We reviewed the areas for improvements/recommendations made at the last inspection. An assessment of compliance was recorded as met, partially met and not met.

The preliminary findings of the inspection were discussed at feedback to the service at the conclusion of the inspection.

6.0 The Inspection

6.1 Review of Areas for Improvement from the Last Inspection dated 5 to 7 June 2017

Areas for Improvement		**Validation of Compliance**
Number/Area 1 **Ref**: Quality Standard 5.3.1(f) **Stated:** Second Time	<u>Policies and procedure</u> The Clinical Supervision policy and Complaints policy was not up to date.	**Not Met**
	Action taken as confirmed during the inspection: Inspectors confirmed that the Trusts Clinical Supervision policy and Complaints policy were not up to date. This area for improvement has been restated for a third time and is therefore subject to RQIA escalation procedures.	

Number/Area 2 **Ref**: Quality Standard 5.3.1(a) **Stated:** Second Time	Personal Well-Being Plans The ward round template was not always completed with the responsible person / team for completing the actions or a time frame. **Action taken as confirmed during the inspection**: Inspectors reviewed four sets of patient care records. Ward round minutes completed for each patient detailed the name of the responsible person for completing actions agreed as an outcome of the ward round meeting.	**Met**
Number/Area 3 **Ref**: Quality Standard 5.3.1 (a) **Stated:** Second Time	Occupational Therapy (OT) Assessment Records There were no OT assessments completed in relation therapeutic/recreational activities. **Action taken as confirmed during the inspection**: Inspectors met with the ward's Occupational Therapist (OT) and reviewed four sets of patient care records. Inspectors evidenced that OT assessments were completed for each patient in relation to therapeutic/recreational activities.	**Met**
Number/Area 4 **Ref**: Quality Standard 5.3.1 (f) **Stated:** First Time	The use of covert medication There was no trust policy to govern the use of covert medication. **Action taken as confirmed during the inspection**: The dementia services co-ordinator with responsibility for the Gillis ward had completed a protocol on the use of covert administration of medication in the Gillis ward. However, this protocol was in draft form and was not a Trust policy.	**Partially met**

Number/Area 5 **Ref**: Quality Standard 5.3.1 (a) **Stated:** First Time	Restrictive Practice The use of restrictive practices was not completed in accordance with Trust policy and procedures.	**Met**
	Action taken as confirmed during the inspection: Inspectors reviewed the ward's procedures for the management of restrictive practices. This included the use of a locked door, use of restraint, enhanced observations and the removal of patients' personal items. Inspectors evidenced that restrictive practices were being implemented (when assessed as necessary for patient safety and wellbeing) in accordance with trust policy and procedure. This included the use of appropriate monitoring forms and mechanisms in conjunction with the trust's governance department. It was also good to note that use of restrictive practices was being monitored consistently by the ward's consultant psychiatrists and the MDT.	
Number/Area 6 **Ref**: Quality Standard 6.3.2 (g) **Stated:** First Time	Carers advocate There was no carers advocate in the centre.	**Met**
	Action taken as confirmed during the inspection: Relatives and carers of patients could access support from a carers advocate as required. The ward's senior management team had arranged with the CAUSE mental health advocacy service to ensure carers and relatives could access a carers advocate as required.	

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.

Patients (were appropriate and in accordance to patient's presenting needs) or their relatives/carers were involved in designing and managing their risk management plans. Patient care records reviewed by inspectors evidenced continued assessment of the presenting risks for each patient. Inspectors noted evidence of weekly MDT review and consultation with patients and their families/relatives. This included a family meeting with the consultant within two weeks of a patient's admission. Discharge planning meetings and associated family meetings were also convened prior to the patient's discharge.

Patients who met with inspectors stated that they felt safe on the ward. Relatives who met with inspectors reported that they felt the ward was a safe and positive place for patients.

Patients' assessments and care plans were specific, patient centred, up to date and reviewed on a regular basis. Risk assessments were noted to be up to date and reviewed on a weekly basis and as required. Outcomes of risk assessments were used to inform each patient's care plan. This included the use of restrictive practices when required. Restrictive practices were monitored in accordance to the required standards. On the days of the inspection four patients were subject to continuous observations. Observations were noted as being carried out sensitively and in the interests of the patient.

The ward's health and safety risk assessment was completed by the ward manager in January 2018. The assessment identified and rated presenting risks and provided associated action plans. An environmental suicide and ligature point risk assessment tool and action plan had been completed in May 2018. The tool identified a number of ligature points which were being managed at a local level. This arrangement had been assessed as suitable based on the presenting needs of the patients. The ligature risk management plan was kept under continuous review and any patient presenting with a ligature risk was managed on a 1 to 1 basis.

Inspectors evidenced that the ward implemented robust arrangements for the discharge of statutory functions, in accordance with the Mental Health (Northern Ireland) Order 1986.

Area for Improvement

The ward's operational guidelines required approval by the trust's executive management team. An area for improvement in relation to this has been made in the quality improvement plan at the end of this report.

Number of areas for improvement	1

7.2 Is Care Effective?

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

Areas of Good Practice

Files reviewed by inspectors evidenced that the ward's MDT comprehensively assessed each patient's needs. This included all aspects of each patient's physical and mental health presentation. Inspectors reviewed physical, nutrition and fluid balance charts and spoke with all staff professions within the MDT. Care and treatment to patients was noted as being completed in accordance to the required standards.

Patient care plans reviewed by inspectors evidenced that patients were assessed in accordance to their individual needs. Care plans were personalised, reviewed on a weekly basis (and as required) and time bounded in terms of overall review of patient progress. Each patient's circumstances were reviewed weekly at one of the ward's three MDT meetings. The ward convened three MDT meetings each week in line with reviews for each of the three consultants and their respective patients. MDT minutes reviewed by inspectors were noted to be comprehensive, up to date and included agreed action plans and the name of the person responsible for implementing the action.

Care records reviewed by inspectors evidenced that care and treatment was provided to patients in accordance to best practice guidelines. Patients could access specialist assessments and interventions as required. Discharge planning for each patient was commenced early in their admission. Patients and their relatives/carers were involved in their discharge planning.

The ward environment was well maintained and staff promoted a therapeutic and recovery based approach. Use of restrictive practices was proportionate, closely monitored and reviewed and audited on a regular basis.

Weekly MDT meetings and minutes evidenced that each patient's progress and readiness for discharge was reviewed and considered on a consistent basis. Records evidenced that families were involved in the care and treatment of their relative. It was positive to note that the ward implemented John's campaign and relatives could visit the ward throughout the day.

Patients discharged from the ward remained under the care of the same consultant psychiatrist. This provided consistency for the patient in terms of their admission and discharge journey and in relation to their care and treatment in the community.

Area for Improvement

Patient care plans had not been transferred onto the Trusts electronic PARIS patient information system. An area for improvement in relation to this has been made in the quality improvement plan at the end of this report.

Number of areas for improvement	1

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 who met with inspectors stated that staff treated them well and with respect. At the time of the inspection there were twenty two patients admitted to the ward. Not all patients could communicate verbally due to their illness. Inspectors observed care practices throughout the inspection and noted that nursing and MDT staff provided patient focussed and attentive care. Patient requests were responded to quickly and staff were consistently available throughout the ward. Patients who presented in an unsettled state were quickly comforted and provided with reassurance.

Patient care records evidenced that patients and their families/carers were kept up to date regarding care and treatment plans and discharge planning. Family/carers attended a discharge planning meeting prior to the patient's discharge from the ward.

Inspectors evidenced that medical, nursing and MDT staff continually liaised with patients and their relative/carer. Patient care and treatment plans were discussed with patients (when this was appropriate for the patient in terms of the patient's needs and presentation). Continuing care records demonstrated that staff maintained good contact with family/relatives. The ward's relatives/carers survey evidenced that relatives /carers were complimentary about the ward and that the ward provided easy access for families to the ward staff team.

Areas for Improvement

No areas for improvement were identified during the inspection.

Number of areas for improvement	None

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

Patients admitted to the ward were supported by nursing, medical, social work and occupational therapy staff. The trust was in the process of recruiting a speech and language therapist and a part time 0.5 whole time equivalent (WTE) clinical psychologist. With the appointment of these posts the ward's MDT was noted as being appropriate to meet the needs of the patients. The ward was supported by a WTE Occupational therapist and an OT assistant. Therapeutic activities were delivered on a daily basis Monday to Friday. Activities at weekends were nurse led and included visits from patient's relatives, carers and friends.

Staff who met with inspectors reported no concerns regarding their role on the ward or their ability to take action should they have a safeguarding, child protection, escalation or whistleblowing concern.

Staff within the ward provided evidenced based therapeutic interventions. Care and treatment provided within the ward was subject to appropriate governance arrangements. Governance arrangements were also in place to monitor the prescribing and administration of medication.

Staffing levels on the ward on the days of the inspection were appropriate to meet the needs of patients. Staff who met with inspectors stated that they had appropriate training, supervision and appropriate professional development opportunities.

Patients and carer/relatives views were collected and analysed on a regular basis.

Areas for Improvement

No areas for improvement were identified during the inspection.

Number of areas for improvement	None

8.0 Quality Improvement Plan

Areas for improvement identified during this inspection are detailed in the quality improvement plan. Details of the quality improvement 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 quality improvement plan are addressed within the specified timescales.

8.1 Actions to be taken by the Service

The quality improvement 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 quality improvement plan by 23 July 2018.

<table>
<tr><td colspan="2">Quality Improvement Plan
Gillis Memory Centre</td></tr>
<tr><td colspan="2">Priority 1</td></tr>
<tr><td colspan="2">The responsible person must ensure the following findings are addressed:</td></tr>
<tr><td rowspan="2">Area for Improvement No. 1

Ref: Quality Standard 5.3.1 (f)

Stated: Third time

To be completed by:
6 December 2018</td><td><u>Policies and procedure</u>

The Clinical Supervision policy and Complaints policy was not up to date.</td></tr>
<tr><td>Response by responsible person detailing the actions taken:
Following communication between Senior Trust managers and RQIA agreement has been reached between the Trust and RQIA that the current clinical Supervision Policy and the Complaints Policy are reviewed as interim policies as of July 2018. These policies will be reviewed again in line with the regional reviews.</td></tr>
<tr><td rowspan="2">Area for Improvement No. 2

Ref: Quality Standard 5.3.1 (f)

Stated: Second time

To be completed by:
6 December 2018</td><td><u>The use of covert medication</u>

There was no trust policy to govern the use of covert medication.</td></tr>
<tr><td>Response by responsible person detailing the actions taken:
The final draft of the Protocol for Gillis Memory centre to govern the use of covert medications is currently in with SMT for review and sign off. Once this is completed the Trust will advise RQIA of this action.</td></tr>
<tr><td colspan="2">Priority 2</td></tr>
<tr><td rowspan="2">Area for Improvement No. 3

Ref: Quality Standard 5.3.1 (f)

Stated: First time

To be completed by:
6 December 2018</td><td>The ward’s operational guidelines need to be approved by the trust’s executive management team.</td></tr>
<tr><td>Response by responsible person detailing the actions taken:
The final draft of Gillis Operational Guidelines is currently with SMT for review and sign off. Once this is completed the Trust will advise RQIA of this action.</td></tr>
</table>

Priority 3	
Area for Improvement No. 4 **Ref:** Quality Standard 5.3.1 (a) **Stated:** First time **To be completed by:** 6 December 2018	Patient care plans require to be transferred onto the Trusts electronic PARIS patient information system. **Response by responsible person detailing the actions taken:** The transfer of patient care plans has been arranged with the PARIS team. Training has been arranged for the 30th July 18 to begin the pilot in order to ensure the process is seamless. Once completed the Trust will advise RQIA of this action.

Name of person(s) completing the quality improvement plan	Sally Kennedy		
Signature of person(s) completing the quality improvement plan	S. Kennedy	**Date completed**	19/07/2018
Name of responsible person approving the quality improvement plan	Adrian Corrigan		
Signature of responsible person approving the quality improvement plan	A. Corrigan	**Date approved**	23/07/2018
Name of RQIA inspector assessing response			
Signature of RQIA inspector assessing response	Alan Guthrie	**Date approved**	26/07/2018

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