Mental Health and Learning Disability Inpatient Inspection Report
21 – 23 March 2017

Rosebrook
Psychiatric Intensive Care Unit
Bluestone Unit, Craigavon Area Hospital
68 Lurgan Road
Portadown
BT63 5QQ
Tel No: 028 3836 0678

Inspectors: Wendy McGregor, Dr Chris Kelly

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

Rosebrook is a ten bedded psychiatric intensive care unit (PICU) providing care and treatment to male and female adult patients. The ward is supported by a multi-disciplinary team that includes a consultant psychiatrist, medical staff, nursing staff, an occupational therapist and a social worker. Patients can be referred to the clinical psychologist who is based in the Bluestone hospital.

On the first day of the inspection there were ten patients on the ward, the number of patients reduced to nine on day two and day three. Eight patients were detained in accordance with the Mental Health (Northern Ireland) Order 1986. One patient was voluntary.

3.0 Service Details

Responsible person: Stephen McNally	
Ward manager: Wendy Kelly	
Person in charge at the time of inspection:	**Day 1 – Chris Higgins** **Day 2 & 3 – Wendy Kelly**

4.0 Inspection Summary

An unannounced inspection took place over three days on 21 – 23 March 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 Rosebrook Ward was delivering, safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in relation to a good multi-disciplinary team approach to care, the importance placed on therapeutic and recreational activities and the commitment of staff to look at ways to enhance the service.

Areas requiring improvement were identified in relation to the delay in response from the trust estates department to safety hazards.

Patients said that although they disliked the restrictions of a psychiatric intensive care unit, they understood why they required this level of enhanced care. Patients confirmed that they were satisfied with the care they were receiving and that the staff were helpful. Although patients presented as very unwell, all confirmed that their admission to Rosebrook had helped them and that they felt they had improved since their admission.

Patients said:

“There are activities on the ward.”

“Staff informed me why I was admitted.”

“I know I have got better, since my admission to 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	4

Preliminary findings of the inspection were discussed with the ward manager, multi-disciplinary team and senior trust representatives 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. A letter of serious concerns was sent to the Acting Chief Executive on 3 April 2017 requesting that the trust agree a revised process with the estates team for prioritising repairs identified as high risk and forward this process to RQIA by 12 April 2017.

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/

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 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 five patients, 11 staff, and one relative.

The following records were examined during the inspection:

- Care documentation in relation to four patients.
- Staff rota.
- Training records.
- Minutes of governance meetings.
- Weekly environmental audit.
- Ward risk register.
- Fire risk register.
- Minutes of staff meetings.
- Minutes of patients forum meetings.
- Care documentation audits.
- Incident and accident dashboards.
- Daily risk records.
- Daily allocation sheet.

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

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

6.0 The Inspection

6.1 Review of Areas for Improvement / Recommendations from the Most Recent Inspection dated 2 February 2017

The most recent inspection of Rosebrook Ward was an unannounced inspection. The Quality Improvement Plan (QIP) was returned and approved by the responsible inspector. This QIP was validated by inspectors during this inspection.

6.2 Review of Areas for Improvement / Recommendations from Last Inspection dated 2 February 2017

Recommendations		Validation of Compliance
Number 1 **Ref**: Quality Standard 5.3.3(d) **Stated:** First Time	It is recommended that he ward manager ensures that nursing staff continually supervise the ward's main communal area.	**Met**
	Action taken as confirmed during the inspection: The inspector noted that there was an allocation sheet available which detailed the staff responsible for supervising the communal areas on the ward. Inspector observed staff to be present in the communal areas at all times during the inspection.	
Number 2 **Ref**: Quality Standard 4.3 (m) **Stated:** First Time	It is recommended that the ward manager ensures that staff receive training in relation to restrictive practices and deprivation of liberty (DOLS).	**Met**
	Action taken as confirmed during the inspection: The inspector reviewed the training records for staff working on the ward. 10 out of 18 staff had received up to date training in restrictive practices and Deprivation of Liberty (DOLS). The inspector noted that the eight staff who had not attended the training were newly employed staff. The ward manager confirmed that training was provided by the Clinical Education Centre (CEC) but the dates had not been confirmed yet. In the meantime the ward manager will provide awareness sessions to staff, which will be delivered by staff who have received the formal training and have the knowledge and skills in relation to restrictive practices and deprivation of liberty.	

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

In the four sets of care documentation reviewed there was evidence that each patient had an up to date risk assessment in place. These were noted to be individualised, comprehensive and were completed by the doctor. There was evidence of multi-disciplinary involvement. Each risk identified had a plan in place to manage the risk. The risk assessments and plans were reviewed every week and there was evidence of patient involvement.

Fire risk assessments, fire drills, ward environment assessments and ligature risk assessments were up to date. However areas for improvement were noted and have been addressed below.

The deputy ward managers completed weekly environmental checks and collated outstanding areas for repair. This information was escalated to senior management.

The ward manager maintained an up to date ward risk register. All risks identified have control measures in place and were assessed as low, medium, high or extremely high. There was evidence that the risks identified were escalated to senior management. The ward risk register was discussed at the Bluestone governance meetings.

Staff stated they do not work beyond their role, experience, and training. Newly qualified staff nurses confirmed that they had received a good preceptorship and were well supported. Band 5 staff nurses when in charge of the ward said they were supported by other senior staff on site and confirmed that there was an on call system if they required advice and support.

Staff demonstrated their knowledge of safeguarding vulnerable adults procedures and the management of incidents and accidents. From the safeguarding vulnerable adults and incident records reviewed; referrals were noted to be appropriate and actioned in accordance with trust policy and procedures.

Patients confirmed they were informed of their rights and knew the reason why they had been admitted to PICU.

The advocacy service was good. The advocate attends the ward every week and facilitates patient forum meetings.

The inspector noted that all patients were detained in accordance with the Mental Health (Northern Ireland) Order 1986.

Each patient had a care plan in place that addressed restrictive practices and deprivation of liberty (DOLS). There was evidence that restrictions were proportionate to the risk and were in the patient's best interests.

Staff reviewed restrictions every day and at the weekly multi-disciplinary team meetings. There was evidence that patients were appropriately discharged from PICU to an open ward or the restriction reduced (in the case of enhanced observations) when the patient no longer required that level of restriction.

Consent was considered and clearly recorded in patient records. Patients were offered and encouraged to participate in ward activities and their right to decline was respected. Staff actively encouraged patients to comply with their care and treatment but respected patient's right to refuse.

Areas for Improvement

Environmental

During the inspection inspectors were concerned that there was a delay in the response by the Estates Services Department to repair serious safety hazards and address recommendations from the environmental risk assessments, fire risk assessments and ligature risk assessments. A letter was sent to the Chief Executive requesting confirmation that this will be addressed by 12 April 2017.

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

There was evidence in the four sets of care documentation reviewed that patient's needs were comprehensively assessed. Each patient had an individualised recovery based care plan in place. There was evidence of ongoing evaluation of care and treatment. Care plans were reviewed every day.

There was evidence that staff actively encouraged and sought patient involvement in their care plans. The reason was recorded when a patient was not involved.

Patients were offered the opportunity to attend their weekly multi-disciplinary team meeting. When patients declined to attend, staff discussed the outcomes of the meeting with the patient.

Patients had access to a full multi-disciplinary team that included occupational therapy (OT) and clinical psychology. Patients interviewed spoke highly of the OT service and one patient who was seeing the clinical psychologist stated they found the sessions very beneficial.

Patients confirmed that they had felt better since their admission to PICU.

The ward social worker worked closely with families. The ward social worker had worked with some families and provided information to help them understand the nature of their relative's mental illness. This support was also provided to children of patients.

Accurate and detailed records were maintained to confirm decisions agreed at the ward round, the person responsible for implementing agreed actions was identified and the timeframe for implementation was included. The weekly record audit was another mechanism in place to ensure that these decisions were addressed.

The deputy ward manager completed a comprehensive audit of patient's care documentation every week.

The psychologist was available to staff to discuss patients who would benefit from and require a referral to psychology. The clinical psychologist was involved with one patient in Rosebrook during the inspection. It was good to note that they were proactively getting to know patients by being present on the ward and through attendance at MDT meetings.

Staff have been trained in Rapid, Assessment, Interface and Discharge (RAID).

There was a good range of therapeutic and recreational activities and the opportunity for community living based activities. The activities focused on recovery and health promotion. Patients and staff were observed participating in an exercise programme called "Everyone

Active", which was facilitated by an outside agency. The inspector noted the therapeutic benefit of the "Everyone Active" exercise programme and observed patients enjoyed participating.

There was a dedicated consultant psychiatrist on the ward.

The documentation reviewed evidenced that restrictive practices were used as a last resort and this was further confirmed by staff who were interviewed during the inspection. There was evidence that staff and patients received a debrief after every incident. This was formalised and documented.

The environment was therapeutic. Each patient had their own bedroom and en-suite; there were dedicated activity spaces, open access to the garden and quiet areas for patients to retreat to. The ward was observed to be clean, tidy, well lit and spacious.

Areas for Improvement

Multi-disciplinary team record

The template for the multi-disciplinary team record was not consistently completed by nursing and medical staff.

Pharmacy input

Pharmacy input to the ward was infrequent. The ward manager had highlighted this as a risk and had recorded it on the ward risk register and completed an incident record on DATIX. The ward manager does not receive any outcomes from pharmacy visits and the pharmacist does not attend the MDT meeting.

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

Staff responded compassionately to patients who were in distress.

Staff were observed to be kind and courteous when observed engaging with patients.

Patients were satisfied with their care. Patients spoke highly of staff and said staff were approachable and they felt listened to.

The inspectors observed staff participate in activities along with patients, which was noted to develop a therapeutic relationship between patients and staff.

Staff knew the support needs of patients very well. Staff spoke in a positive way about patients.

There was good advocacy support. There was evidence that the advocate was proactive on the ward and attended patient forum meetings every week. The advocate also attended staff meetings on occasions. There was evidence that the advocate proactively followed up on patient complaints.

Patients confirmed they knew why they were admitted to PICU.

Areas for Improvement

No areas for improvement 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

The consultant psychiatrist attended a regional meeting to share best practice.

Staff meetings occurred every month.

There was a mechanism in place to share learning from incidents with staff.

Staff demonstrated their commitment to improving the service and sharing best practice. Staff were keen to pursue benchmarking the service against the standards in accordance with National Association of Psychiatric Care and Low Secure (NAPICU). The ward should consider peer review.

The deputy ward manager will be sharing best practice in relation to restraint at a regional conference this month.

Staff all said they were well supported.

Support mechanisms were in place for staff. Supervision and appraisals were up to date and reflective practice sessions were available for the MDT.

There was evidence of a multi-disciplinary approach to care. Staff confirmed that the MDT worked well together.

The inspector found it was easy to review the patient's journey on the patient electronic care recording system (PARIS).

Mandatory training was up to date.

There was good administration support on the ward.

Areas for Improvement

Governance oversight of restrictive practices

There was no governance oversight on the use of restrictive practices. The frequency of restrictive practices such as physical interventions, seclusion, and rapid tranquilisation was not collated. Collating of this information would have enhanced the service and informed care and practice.

Physical interventions were not included on the dashboard. This information was not easily obtainable from the incident reporting system (DATIX).

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 **17 May 2017**.

<table>
<tr><td colspan="2">Provider Compliance Plan
Rosebrook</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 (a)

Stated: First time

To be completed by:
12 April 2017</td><td><u>Environmental</u>

During the inspection inspectors were concerned that there was a delay in the response by the Estates Services Department to repair serious safety hazards and address recommendations from environmental risk assessments, fire risk assessments and ligature risk assessments.</td></tr>
<tr><td>Response by responsible person detailing the actions taken:
The immediate concerns raised by RQIA were addressed during the Inspection period. After the inspection the Assistant Director and Head of Service for Bluestone met with senior management from Estates and agreed an escalation process to respond to Minor works and maintenance requests. The Estates dept have identified a nominated Head of Service to work directly with Bluestone. The Head of Service meets with the Head of Estates fortnightly to monitor progress. The Environmental Safety Audit continues to be completed weekly by nursing staff and updated as repairs are completed. Safety concerns surrounding the Extra Care Suite (ECS) door are being addressed and a</td></tr>
</table>

	suitable replacement to fulfil the requirements for this area is being sought. CCTV Camera concerns within the ECS have also been addressed and completed.

Priority 2	
Area for Improvement No. 2 **Ref:** Quality Standard 5.3.1 (a) **Stated:** First time **To be completed by:** 23 May 2017	<u>Multi-disciplinary team record</u> The template for the multi-disciplinary team record was not consistently completed by nursing and medical staff.
	Response by responsible person detailing the actions taken: This has been addressed and resolved by the MDT and the record is consistently completed to reflect medical and nursing input at the MDT meeting. To ensure this continues the MDT record is audited weekly by Senior Staff Nurse.
Area for Improvement No. 3 **Ref:** Quality Standard 5.3.2 **Stated:** First time **To be completed by:** 23 June 2017	<u>Governance oversight of restrictive practices</u> There was no governance oversight on the use of restrictive practices. The frequency of restrictive practices such as physical interventions, seclusion, and rapid tranquilisation was not collated. Collating of this information would have enhanced the service and informed care and practice. Physical interventions were not included on the dashboard. This information was not easily obtainable from the incident reporting system (DATIX).
	Response by responsible person detailing the actions taken: The Ward Sister will collate all information pertaining to Restrictive practice to provide a report to the Acute Governance group for oversight. The Trust continues to work on ensuring the Restrictive physical intervention form is being added to the DATIX and subsequently to the dashboard. Senior Staff Nurse will continue to audit Restrictive practices. An account of the use of the Extra Care Suite and Seclusion including timing and the use of these interventions is collated. DATIX is used to record the incident and the Restrictive Physical Intervention form keeps accurate and intricate details of the incident and follow up and actions taken. These are reviewed and signed off by the Ward Sister. The Ward Sister will have a Datix dashboard to review any emerging trends.
Area for Improvement No. 4 **Ref:** Quality Standard 5.3.1 (f)	<u>Pharmacy input</u> Pharmacy input to the ward was infrequent. The ward manager had highlighted this as a risk and had recorded it on the ward risk register and completed an incident record on DATIX. The ward manager does

Stated: First time **To be completed by:** 23 May 2017	not receive any outcomes from pharmacy visits and the pharmacist does not attend the MDT meeting.
	Response by responsible person detailing the actions taken: The Pharmacist is now attending MDT meetings regularly and the Ward Manager has been receiving written feedback on the outcome/findings of pharmacy reviews on the ward. The Consultant has had prompt responses to e-mails from the Pharmacist. The Ward Sister will continue to monitor this area for continued improvement.

Name of person(s) completing the provider compliance plan	Wendy Kelly		
Signature of person(s) completing the provider compliance plan		**Date completed**	13/05/2017
Name of responsible person approving the provider compliance plan	Bryce McMurray		
Signature of responsible person approving the provider compliance plan		**Date approved**	22.05.17
Name of RQIA inspector assessing response	Wendy McGregor		
Signature of RQIA inspector assessing response		**Date approved**	24 May 2017

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