The Regulation and Quality Improvement Authority

RQIA

Mental Health and Learning Disability

Unannounced Inspection

Ward 27

Ulster Hospital

South Eastern Health and Social Care Trust

2 April 2014

npm national preventive mechanism

informing and improving health and social care
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1.0 Introduction

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of Northern Ireland's health and social care services. RQIA was established under the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, to drive improvements for everyone using health and social care services. Additionally, RQIA is designated as one of the four Northern Ireland bodies that form part of the UK's National Preventive Mechanism (NPM). RQIA undertake a programme of regular visits to places of detention in order to prevent torture and other cruel, inhuman or degrading treatment or punishment, upholding the organisation's commitment to the United Nations Optional Protocol to the Convention Against Torture (OPCAT).

1.1 Purpose of the Inspection

The purpose of this inspection was to ensure that the service is compliant with relevant legislation and good practice indicators and to consider whether the service provided to patients was in accordance with their assessed needs and preferences.

The aims of the inspection were to examine the policies, procedures, practices and monitoring arrangements for the provision of care and treatment, and to determine the provider's compliance with the following:

- The Mental Health (Northern Ireland) Order 1986;
- The Human Rights Act 1998;
- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003;
- Optional Protocol to the Convention Against Torture (OPCAT) 2002.

Other published standards which guide best practice may also be referenced during the inspection process.

1.2 Methods/Process

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

- discussion with patients and/or representatives;
- discussion with multi-disciplinary staff and managers;
- examination of records;
- consultation with stakeholders;
- file audit; and
- evaluation and feedback.

Any other information received by RQIA about this service and the service delivery has also been considered by the inspector in preparing for this inspection.

2.0 RQIA Compliance Scale Guidance

The inspector has rated the ward's Compliance Level against each recommendation made following the previous inspection.

The table below sets out the definitions that RQIA has used to categorise the ward's performance:

Guidance - Compliance statements		
Compliance statement	**Definition**	**Resulting Action in Inspection Report**
0 - Not applicable	Compliance with this criterion does not apply to this ward.	A reason must be clearly stated in the assessment contained within the inspection report
1 - Unlikely to become compliant	Compliance will not be demonstrated by the date of the inspection.	A reason must be clearly stated in the assessment contained within the inspection report
2 - Not compliant	Compliance could not be demonstrated by the date of the inspection.	In most situations this will result in a requirement or recommendation being made within the inspection report
3 - Moving towards compliance	Compliance could not be demonstrated by the date of the inspection. However, the service could demonstrate a convincing plan for full compliance by the end of the inspection year.	In most situations this will result in a recommendation being made within the inspection report
4 - Substantially Compliant	Arrangements for compliance were demonstrated during the inspection. However, appropriate systems for regular monitoring, review and revision are not yet in place.	In most situations this will result in a recommendation, or in some circumstances a recommendation, being made within the Inspection Report
5 - Compliant	Arrangements for compliance were demonstrated during the inspection. There are appropriate systems in place for regular monitoring, review and any necessary revisions to be undertaken.	In most situations this will result in an area of good practice being identified and being made within the inspection report.

3.0 Ward Profile

Trust	South Eastern Health and Social Care Trust
Name of hospital/facility	Ulster Hospital, Ward 27
Address	Upper Newtownards Road Dundonald County Down BT16 1RH
Telephone number	028 90484511
Person-in-charge on day of inspection	Catherine Gilmore
Email address	Catherine.Gilmore@setrust.hscni.net
Nature of service - MH/LD	Mental Health
Name of ward/s	Ward 27
Date of last inspection	14 November 2013
Name of Inspector	Alan Guthrie

Ward 27 is a 24 bed acute admissions unit located within the Ulster Hospital, Dundonald. The ward is on the first floor of the elderly care unit and operates a locked door policy. Ward 27 is a mixed gender ward and it provides treatment and care to adults including people aged over 65 years. The ward is supported by three Consultant Psychiatrists and their respective teams. Patients are accommodated in bays with four beds, segregated into male and female areas. There are also four single bedrooms.

At the time of the inspection there were 24 patients on the ward, six of whom were detained under the Mental Health (Northern Ireland) Order 1986. Three patients were receiving prescribed observations.

4.0 Inspection Summary

An unannounced inspection of Ward 27 was undertaken on 2 April 2014.

The purpose of this inspection was to evaluate the progress on implementing the recommendations made following the last inspection on 14 November 2013.

During the course of the inspection the inspector met with eight patients, nine staff and two carers/relatives. Patient notes, ward records and a number of the ward's patient and staff management policies and procedures were also reviewed. Of the 18 recommendations made in the previous Quality Improvement Plan (QIP) the inspector found evidence to confirm that 16 recommendations were compliant. Two recommendations were assessed as being partially compliant.

The inspector reviewed four sets of patient notes. Notes contained admission documentation including confirmation that patients had been given a ward information booklet and that their rights had been explained to them by the admitting nurse. Patients could also discuss any concerns regarding their rights at the patient forum which was convened by the ward's patient peer advocate on a fortnightly basis. Patients could also access the ward's independent advocate as required.

The inspector found patient notes to be well-ordered and appropriately presented. Patient care plans were personalised and developed on the basis of the assessed needs of each patient. The inspector noted that patient signatures were available where required. Patients who met with the inspector reported that they had been informed about their treatment and that the reasons why they were in hospital had been discussed with them. The inspector was informed that the Trust was planning to incorporate patient care plans onto the Trust's maxims patient information system. This would ensure that information in relation to care plans, and subsequent care plan reviews, would be stored in the same location making it easier for members of the multi-disciplinary team to access. A recommendation supporting the transfer of patient care plans from paper copy to the maxims system has been made.

The ward had complied with recommendations relating to staff induction and training. The inspector noted that 27 of the ward's 29 staff had completed complaints training and 29 staff had completed safeguarding vulnerable adults training. The ward's training records were comprehensive and clearly presented. Records detailed that mandatory training in fire safety training, self-harm and suicide awareness and the management of aggression had been completed by the majority of staff. Any shortfalls regarding staff mandatory training had been highlighted by the ward manager and appropriate steps had been taken to address the training deficit. Staff who met with the inspector reflected that access to training had improved and supervision and appraisal schedules had been agreed. The inspector noted

that 50% of the nursing staff team had received supervision from December 2013 and dates to provide supervision and appraisal for the remaining staff members had been identified.

The ward manager had devised a ward standard operating procedure (SOP) folder. The folder included information regarding the policies and procedures staff were required to adhere to when delivering care and treatment to patients. The SOP folder detailed the procedures in relation to recording complaints, reporting incidents, the use of physical interventions and when monitoring patients who had been prescribed close observation. Records reviewed by the inspector detailed that the recording and reporting of incidents, complaints and restrictive practices had been completed in accordance with Trust policy and procedure.

Two of the recommendations reviewed were only partially met. Both recommendations related to the handling of patient monies and valuables. A financial inspection of ward 27 completed by RQIA in January 2014 found that the processes around the management of patients' valuables were not robust and were governed by an out of date policy. The Trust detailed that the implementation of a new finance system had delayed the review of the Trust's finance policy. Given the outcome of the RQIA finance inspection and the explanation provided by the Trust the two partially met recommendations will not be restated. However, a number of recommendations have been made to ensure that the Trust provides staff with the required support to implement the recommendations made as a result of the finance inspection. This includes a recommendation requiring the Trust to confirm the date when the new finance system and revised finance policy will be implemented.

Inspectors would like to thank the patients, staff, relatives and visiting professionals for their cooperation throughout the inspection process.

1.0 FOLLOW-UP ON PREVIOUS ISSUES

1. Recommendations restated from the inspection completed on the 19 and 20 October 2010

No.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1.	It is recommended that the ward manager ensures that all patients are advised of their rights and what they can expect in terms of care and treatment, in a manner appropriate to their understanding.	The acute psychiatry admission/discharge nursing documentation sheet included a section regarding the information given to patients and their carer. The section specified that the admitting nurse ensure that patients were given an information booklet and that the patient understood the information contained in the booklet. The inspector reviewed four sets of patient notes and found that records stating that admission information had been given to and discussed with each patient. Patients' could also discuss any concerns regarding their rights at the patient forum which was convened by the ward's patient peer advocate on a fortnightly basis. Patients could also access the ward's independent advocate as required.	Fully met
2.	It is recommended that the ward manager ensures that the ward's admission documentation includes confirmation that patients have received information regarding their rights.	The patient information booklet detailed the ethos and culture of the ward. The booklet also discussed patient's rights in relation to leaving the ward, making a complaint, contacting the ward's advocate, expectations and patient care and the patient's right to meet with all professionals involved in providing their care. Each patient was given an information booklet upon admission. Confirmation that patients had received information regarding their rights was noted on each of the four files reviewed by the inspector. Patients who met with the inspector detailed that their contact with the ward's nursing staff, upon admission, was positive	Fully met

		and staff were reported as having been approachable, helpful and supportive.	
4.	It is recommended that the ward manager ensures that all patients are informed of and involved in a person centred assessment and care planning process	The inspector reviewed four sets of patient notes. Notes were tidy, well ordered, easy to follow and appropriately presented. Recording and monitoring of patient progress was supported by the Trust's maxims computer programme. Maxims' entries relating to the four patient files reviewed by the inspector detailed that patient care plans were reviewed on a regular basis and that the reviews were completed with the patient. Patients who met with the inspector reported that they understood why they were in hospital and nursing staff had discussed their treatment with them. Patient care plans were personalised and developed on the basis of the assessed needs of each patient. The inspector noted that patient signatures were available where required. The inspector was informed that the Trust was planning to incorporate patients' care plans onto the maxims system. This would ensure that information in relation to care plans and subsequent reviews would be stored in the same place making it easier for the multi-disciplinary team to access. A recommendation supporting the transfer of patient care plans from paper copy to the maxims system has been made.	Fully met
5.	It is recommended that the Trust ensures that clear documented systems are in place for the management and filling of records in accordance with professional and legislative requirements.	Files reviewed by the inspector were presented to an appropriate standard. Patient continuous progress and review notes were recorded on the Trust's maxims system. The inspector reviewed two sets of patient progress records on the maxims system and found these to be comprehensive and completed to a good standard. The two sets of electronic records reviewed detailed that nursing staff had provided up to six daily entries for each patient including detail of contact and conversions with patients' relatives. This provided a continuous record of patient progress and an easy to follow patient treatment history.	Fully met

2. Recommendations restated from the inspection completed on the 3, 4 and 11 September 2012

No.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
9.	It is recommended that the ward manager ensures ward staff are appropriately trained in the management of aggression.	The inspector reviewed the training records for the ward's nursing team. Training records were maintained on the Trust's e-rostering computer software. The records indicated that 28 of the ward's 32 staff had completed up to date control and restraint (C & R) training. Four members of staff had not completed updated C& R training due to long term absence. The inspector was informed that the Trust would be transferring all staff to managing actual and potential aggression (MAPA) training in the near future.	Fully met
13.	It is recommended that the Trust ensures policies that support safe and effective care are reviewed and updated as necessary.	RQIA completed a finance inspection of the South Eastern Health and Social Care Trust in January 2014. The inspection detailed that the processes around the management of patients' monies and valuables were not robust and were governed by an out of date policy. The inspector noted that the Trust's Handling of Patient Cash and Valuables Policy was to have been reviewed by 31 March 2014. The Trust informed RQIA that it was in the process of implementing a new finance system and that its policy would be updated accordingly upon the implementation of the new system. A recommendation has been made directing the Trust to update and issue guidance to staff that addresses the recommendations made in the finance inspection quality improvement plan. A further recommendation has been made to ensure that ward staff are provided with training in the implementation of the finance	Partially met

		inspection recommendations. Finally, it is recommended that the Trust confirms to RQIA the agreed date by which the policy on the management of patients' monies and property will be revised and implemented.	
14.	It is recommended that all incidents of abuse, falls and patient on patient assaults are forwarded to the governance department.	The ward management team had developed a local vulnerable adult (VA) policy to help ensure that staff completed VA referrals in accordance with Trust and regional policy and procedure. The inspector reviewed the ward's VA process and noted that VA referrals were completed appropriately and forwarded in a timely manner. The inspector noted that vulnerable adult concerns remained a standing item on the staff meeting agenda. Records of the vulnerable adult referrals forwarded by the ward revealed that acknowledgment receipts (VA2) had been forwarded by the designated officer (DO) within the required timescales. The ward manager relayed that communication with the DO was positive and ongoing. It was also good to note that all nursing staff (currently available for duty: 3 staff off on long term leave) had completed safeguarding vulnerable adults training.	Fully met
16.	It is recommended that the ward manager ensures all staff have completed training in self-harm and suicide awareness and prevention techniques.	Ward staff training records detailed that 25 members of the nursing team had completed up to date training in self-harm and suicide awareness and prevention techniques. Four members of the staff team were due to complete training in the near future. The inspector noted that of the seven staff members	Fully met

		whose training was still to be completed three were off on long term absence and three had been scheduled to complete training on the 11 March 2014. This training was cancelled by the training provider. The inspector was satisfied from the evidence available that the ward management team had taken the necessary steps to ensure that all staff had the opportunity to complete training.	
17.	It is recommended that physical interventions records are completed in accordance with the Trust's policy and in accordance with DHSSPSNI Guidance on Physical Interventions (2005).	The inspector reviewed the ward's incident reporting procedures and the use of physical intervention monitoring form. Incident reporting forms (IR1) generated as a result of the required use of physical intervention, by nursing staff, were completed in accordance with Trust policy and procedure. The physical intervention monitoring form contained appropriate detail and was cross referenced with the corresponding IR1 form. The inspector noted that incident reporting and vulnerable adult referrals were a standing item on the ward staff meeting agenda.	Fully met
18.	It is recommended that the Trust encourage staff to use the incident reporting system to highlight any instances of unsafe staffing levels and this matter should be raised at staff meetings.	The inspector reviewed incident forms completed from 1 January 2014. One form completed on 30 March 2014 detailed that the ward had been short staffed. The inspector discussed staffing issues with a number of the ward staff. Staff reported that they did complete incident forms to highlight staffing shortages. Staffing levels within the ward was a standing item on the staff meeting agenda.	Fully met
19.	It is recommended that the ward manager ensures relatives are informed of any incidents requiring	The inspector reviewed incident reporting forms (IR1) completed from the 1 January 2014. Each IR1 form contained a check box to ensure that the report's	Fully met

	completion of an IR1, involving their relatives. Where this does not happen the reasons should be clearly stated.	author had considered contact with the patient's relative. A number of IR1 forms detailed that relatives had been contacted. However, a number of forms detailed that relatives had not been contacted. Where a relative had not been contacted the inspector noted that a reason for non- contact had been provided. In discussing this matter with the ward manager the inspector was informed of situations where patients, with capacity, had not consented to staff contacting their relative.	
24.	It is recommended that the ward manager ensures that the Trust policy on the handling of patient's money and valuables is adhered to.	The inspector examined the ward's procedures for managing patient monies and property and found these to be appropriate. However, the Trust policy on the handling of patient's money and valuables was out of date. Recommendations have been made.	Partially met
28.	It is recommended that the ward manager ensures that nursing staff minimise the use of standardised care plans and develop personalised care plans for each patient.	Patient care plans reviewed by the inspector were person centred and personalised. Plans contained both standardised plans and handwritten entries specific to the assessed individual needs of each patient. Patient signatures were available when required.	Fully met
29.	It is recommended that the Trust ensures that all staff undertake fire safety training and fire drills should be undertaken.	Training records for ward staff detailed that all staff had completed the Trust's fire awareness online training. 65% of ward staff had completed up to date face to face fire training with a further 25% due to complete their training on the 8 April 2014. Completion of fire training for 10% of the staff remained outstanding as three staff were off on long term leave. The inspector was satisfied that the ward management team had taken the necessary steps to ensure that all	Fully met

		ward nursing staff had completed up to date fire training. The ward had completed a fire drill on 22 January 2014.	

3. Recommendation made following the inspection completed on the 14 November 2013

No.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1.	It is recommended that the ward manager ensures that the ward staffing numbers are accurately reflected in the ward's records.	The ward's e-rostering computer software detailed that the ward had a compliment of 32 staff. The inspector reviewed staff rota records and found that the ward manager had clear oversight of the ward's staffing resources. The inspector noted that due to the complexity of need within the patient group the ward continued to rely on bank and agency staff on a regular basis.	Fully met
2.	It is recommended that the Trust review the medical support within Ward 27 to ensure effective use of medical and ward staff resources. (Four Consultants/four nursing teams).	Staffing records detailed that the ward's compliment of Consultant Psychiatrists had been reduced to three supported by three nursing teams. The inspector was informed that the nursing teams worked in unison to ensure that the needs of all patients within the ward were met.	Fully met
3.	It is recommended the ward manager ensures that nursing staff receive supervision and appraisal in accordance to Trust and professional standards.	Supervision and appraisal records revealed that 50% of the nursing staff had received supervision and appraisal and dates for the remaining staff had been identified. The ward management team's supervision template was appropriate and the supervision schedule was clear and appropriately detailed.	Fully met
4.	It is recommended that the ward	Nursing staff training records detailed that the majority	Fully met

	manager ensures that nursing staff have completed the required mandatory training.	of nursing staff had completed their required mandatory training. Deficits in training noted by the inspector were discussed and a reasonable explanation was given in each instance. Explanations included staff being unavailable for work for long periods and cancellation of training by the training facilitator. The ward manager had taken appropriate steps to address training deficits.	

6.0 Stakeholder Engagement

The following information is a summary of feedback received from those who met with an inspector during the inspection.

Patients: Patients who met with the inspector detailed:

“I feel it’s (the ward) very well run but understaffed at times”;

“Staff are very good”;

“I can’t fault the staff”;

“Staff are run off their feet”;

“It’s very boring at times”;

“Staff are great”.

Carers/ Relatives: Carers/relatives who met with the inspector detailed:

“…our relative is being well looked after”;

“I have no problems with the ward or the staff”.

Visiting professionals: The inspector was unable to meet with visiting professionals.

Staff: Staff who met with the inspector detailed:

“…more positive place to work…changes are taking place”;

“Access to supervision and training has improved”;

“It is extremely busy and there is significant pressure on staff”;

“I find my role here anxiety provoking and stressful”;

“Support and domestic staff need to be trained to work in mental health”.

Advocates: The inspector was unable to meet with the ward’s advocate(s).

7.0 Additional Concerns Noted by Inspectors (if applicable)

The inspector noted that the ward's maxims system was being utilised to record patient progress and there were daily entries into the system, which provided detailed and accurate information regarding each patient's situation. However, reviews of patient's care plans, although discussed in the patient maxims progress notes, were retained in hard copy on the patients file and not accessible on the maxims system. The inspector was informed that the maxims system could be used to retain care plans and care plan reviews. This would provide all staff with continued access to each patient's care plan. A recommendation to transfer patient care plans from hard copy to the maxim system has been made.

R3

Quality Improvement Plan

Unannounced Inspection

Ward 27, Ulster Hospital

The issue(s) identified during this inspection are detailed in the inspection report and the Quality Improvement Plan.

The details of the Quality Improvement Plan were discussed with the Ward Manager, the Operational Support Manager and the Director of Mental Health either during or after the inspection visit. Please, refer to Appendix 1 for specific reference documents. The timescales for completion commence from the date of the inspection.

1. Recommendations made following inspection 2 April 2014

No.	Recommendation	MHLD Document No.	Reference	Number of times stated	Details of action to be taken by ward/trust	Timescale
1.	It is recommended that the Trust provides guidance to staff that addresses the recommendations made in the RQIA finance inspection completed in January 2014.	4	Circular HSS(F)57/ 2 009	1	Since the RQIA finance inspection completed in January 2014, the Finance Policy 'Handling of Patient's Cash and Valuables', (SET/Fin (08)2010) was reviewed in April 2014 and is due for next review in April 2017. This policy has now been shared with staff. Staff also adhere to the Standard Operation Procedure (SOP), in place for the management of Patient's cash and valuables. This has been further shared with staff as a reminder of requirments	Immediate and ongoing
2.	It is recommended that the ward manager ensures that all staff	2	Section 1, standard	1	The ward manager has given each staff member copies of	30 June 2014

No.	Recommendation	MHLD Document No.	Reference	Number of times stated	Details of action to be taken by ward/trust	Timescale
	receive training in the implementation of the recommendations made as a result of the RQIA finance inspection completed in January 2014.		5.5, page 4.		the current policy which includes the finance flow chart via hard copy and e-mail copy. Training on this policy has been arranged and will be provided at ward level by the Finance Officer for the finance and cash office department in the Ulster Hospital. We anticipate that this training will be completed by June 2014	
3.	It is recommended that the Trust confirms to RQIA the date when the Trust's revised finance policy will be implemented.	2	Section 1, standard 1.4, page 1.	1	The revised Finance Policy has been implemented with immediate effect from April 2014 and brought to the attention of Ward staff.	12 May 2014
4.	It is recommended that the Trust reviews the ward's care planning procedures, specifically the transfer of care plan records and reviews to the maxims system.	2	Section 2, standard 13.9.page 10.	1	The Trust are currently developing an electronic care plan on the Maxims Electronic Clinical system and upon	31 July 2014

No.	Recommendation	MHLD Document No.	Reference	Number of times stated	Details of action to be taken by ward/trust	Timescale
					completion will be piloted in the Mental Health Inpatient Unit and will then be rolled out across acute Mental Health Inpatient Units.	

NAME OF WARD MANAGER COMPLETING QIP	Sister Catherine Gilmore
NAME OF CHIEF EXECUTIVE / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Brendan Whittle

Inspector assessment of returned QIP				Inspector	Date
		Yes	No		
A.	Quality Improvement Plan response assessed by inspector as acceptable	x		Alan Guthrie	**4 June 2014**
B.	Further information requested from provider				

Appendix 1 – MHLD Reference Documents

MHLD Document Number	Legislation Title
1	AIMS -Older People(2009)
2	AIMS-Working Age Adults(2009)
3	AIMS-Learning Disabilities(2010)
4	Circular HSS(F)57/2009 – Residents' Monies
5	Complaints in HSC: Resolution & Learning (2009)
6	DHSSPS Interim Guidance - Deprivation of Liberty(2010)
7	DHSSPS Guidance - Restraint and Seclusion(2005)
8	Human Rights Act(1998)
9	Improving Dementia Services Reg Strategy(2011)
10	Learning Disability Service Framework(2012)
11	Mental Health(NI)Order(1986)
12	NICE Quality Standard 14-User experience(2011)
13	NICE Clinical Guideline 136 -User experience(2011)
14	OPCAT(2002)
15	Procedure for Reporting & Follow Up of SAIs(2010)
16	Promoting Quality Care(2009)
17	Quality Standards for HSC(2006)
18	Safeguarding VAs-Shared Responsibility(2010)

MHLD Document Number	Legislation Title
19	Safeguarding VAs-Protection Policy & Guidance(2006)
20	Service Framework for Mental Health & Well Being (2011)
21	UN Convention-Person with Disabilities(2006)
22	UN Convention-Rights of the Child(1989)
23	UTEC Guidance(2007)