The Regulation and Quality Improvement Authority

Inspection Report

13 - 22 November 2024

Carrick 2 Assessment and Treatment Unit

Mental Health and Learning Disability Hospital
Holywell Hospital
60 Steeple Road
Antrim
BT41 2RJ

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation/Registered Provider: Northern Health and Social Care Trust (NHSCT)	**Responsible Individual:** Ms Jennifer Welsh Chief Executive, NHSCT
Person in charge at the time of inspection: Ray McCafferty Clinical Services Manager	**Number of registered places:** Three
Categories of care: Acute Mental Health and Learning Disability	**Number of patients accommodated in the ward on the day of this inspection:** Three

Brief description of the accommodation/how the service operates:

Carrick 2 Assessment and Treatment Unit (Carrick 2) provides inpatient assessment and treatment for up to a maximum of three adults over the age of 18 years, with a moderate to severe learning disability.

Located within Holywell Hospital, Carrick 2 is operated by the Northern Health and Social Care Trust, however the service is jointly commissioned with the South Eastern Health and Social Care Trust for patients from within both Trust areas, whose needs cannot be met by mainstream services.

Patients are admitted either on a voluntary basis or detained in accordance with the Mental Health (Northern Ireland) Order 1986.

2.0 Inspection summary

An unannounced inspection took place on 13 November 2024 and concluded on 22 November 2024 with feedback provided to the Northern Health and Social Care Trust (the Trust) Senior Management team (SMT). The inspection team consisted of two care inspectors who were supported by a senior inspector.

The inspection focused on ten key themes which included adult safeguarding (ASG) and incident management, the environment, patient experience, restrictive practices, physical health, mental health, medicines management, patient flow, staffing and governance. Intelligence received prior to the inspection informed the areas of inspection focus.

During the inspection patient care and treatment and the lived experience of patients was observed. Relevant patient care documentation, governance records and staffing information was reviewed and inspectors engaged with members of the senior leadership team, multi-disciplinary team (MDT), staff, patients, and their families.

The inspection concluded that there was effective oversight in relation to incident management and adult safeguarding, there was comprehensive information regarding patient behaviour support with Positive Behaviour Support (PBS) plans in place and there was a focused approach to the review of PBS plans to ensure they remained up to date and reflected the patient's needs. Review of patient care records indicated that some improvement was required in the area of care planning to ensure that all assessed patient needs can be met.

The physical environment within Carrick 2 was restricted in response to the individual needs of some patients. Consequently, patients were unable to move around freely or avail of all of the ward spaces. The limitations within the layout and operation of the ward environment requires review due to the impact upon the provision and variety of activities available to patients. The Trust acknowledged this finding and were committed to continue to actively review and make changes in line with patient safety and wellbeing.

Throughout the inspection, staff were observed to be caring and compassionate in their interactions with patients and demonstrated the required knowledge and skills for their area of practice.

During the inspection the active implementation of Encompass was underway, Encompass is being implemented across all five Health and Social Care Trusts and is the Health and Social Care Programme that creates a single digital care record for every citizen in Northern Ireland. At times this proved challenging for staff who were adjusting to working across three systems, however support was in place from managers.

Areas for improvement were identified in relation to the following; care planning, ligature risk assessments and associated environmental risk documentation, the Trust's process for managing complaints, and the lack of availability of psychology service for patients within Carrick 2.

3.0 How we inspect

RQIA has a statutory responsibility under the Mental Health (Northern Ireland) Order 1986 to make inquiry into any case of ill-treatment, deficiency in care and treatment, improper detention and/or loss to damage or property. Care and Treatment is measured using the Quality Standards (2006) for Health and Social Care to ensure that services are safe, of high quality and up to standard.

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how they were performing at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the Trust to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

In preparation for this inspection, information about the service was reviewed and used to inform Key Lines of Enquiry (KLOE). The Inspection team directly observed patient experiences, staff engagement with patients, how patients spent their day, the reaction to and management of incidents, staffing levels, senior leadership oversight and ward environments. Patient care records, patient discharge arrangements and governance documentation were also reviewed.

4.0 What people told us about the service

Posters and easy read questionnaires were provided to invite staff, patients and other visitors to speak with inspectors and to express their views and give feedback on their experiences of care delivery in Carrick 2.

We spoke with patients, relatives and staff and received a number of completed questionnaires. Relative feedback regarding patient care was in the main positive, however patients held mixed views, there were aspects of good care reported and some areas indicated which were not good, however these were unable to be elaborated on.

Staff reflected that Carrick 2 can be a challenging environment to work in, however spoke positively about their role. All staff expressed that there was good support from colleagues and management. Most staff acknowledged the impact the environmental restrictions in place had upon the therapeutic operation of the ward.

A common theme regarding the limited range and variety of activities offered to patients was reflected by both staff and relatives. This is further addressed at Section **5.2.3.**

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

There were no Areas for Improvement arising from the last inspection on 18 April 2023. The previous inspection determined that Carrick 2 met the standards expected of an inpatient service for persons with a learning disability and assessed that systems were in place to support safe patient care.

5.2 Inspection findings

5.2.1 Environment

The ward environment was assessed against The Royal College of Psychiatrist's (RCP) Standards for Adult Inpatient Learning Disability Services 2016 to determine if it was conducive to the delivery of safe, therapeutic and compassionate care.

Carrick 2 was generally clean and in good order, some minor issues of cleanliness were raised and these were addressed during inspection. The Trust should ensure that patients personal areas are maintained to a satisfactory level and steps are taken to address odours and areas that require extra cleaning promptly.

The ward environment lacked, décor, signage and ward based information for patients and visitors. Whilst it was evident that the environment had been adapted in response to some patient specific needs, the Trust should ensure the availability of ward based information is provided for others, in another way.

Carrick 2 benefits from a communal lounge, a visitor's room, a sensory room and activities space. A small enclosed outdoor garden and the larger hospital grounds can be accessed by patients where appropriate and as part of their recovery or care plan. Due to the assessed needs of the patients, the ward environment was restrictive, this is referenced in more detail in section 5.2.6.

The Fire Risk Assessment (FRA) was reviewed and was up to date. However, records within the Fire file indicated that improved oversight was required in regards to the recording and completion of actions, these were not consistently completed and there was limited evidence that fire drills or equipment checks were being completed. Personal Emergency Evacuation Plan (PEEPS), which inform staff of the level of assistance a patient needs to safely evacuate in an emergency, were in place for all patients.

The Ligature Risk Assessment (LRA) was not up to date and there was no indication an annual review of actions from April 2023 had been completed. Ligature risks identified during inspection were promptly acted upon when raised with ward staff.

The Trust should ensure that ligature risk assessments, and associated records and action plans to address fire and ligature risks are completed in a timely manner and reflect progress and outcomes. This has been identified as an Area for Improvement.

5.2.2 Incident Management and Adult Safeguarding

Adult Safeguarding (ASG) is a term used for activity which prevents harm from occurring and which protects adults at risk where harm has occurred or, is likely to occur without intervention. ASG arrangements and process should be managed in accordance with the Northern Ireland Adult Safeguarding Partnership, Adult Safeguarding Operational Procedures, September 2016, which sets out what is required to provide a safe environment and what actions and responses are required to be taken where adults may be at risk of harm or abuse.

Carrick 2 had a Designated Adult Protection Officer (DAPO) aligned to provide support and guidance to staff as required. There was evidence of positive collaborative working between ward staff and the DAPO.

Staff demonstrated knowledge of ASG processes and adherence to the Regional Policy in identifying and reporting ASG concerns. Staff indicated they felt there were open lines of communication and reported that they felt confident in expressing any concerns with their managers.

All ASG referrals were recorded on the Trust's electronic system for recording incidents (DATIX). Incidents reviewed identified appropriate reporting, categorisation and grading of incidents and escalation to the ASG team where the threshold was met for a referral.

Assurances of robust oversight of DATIX and management of incidents was provided; the ASG senior team were undertaking review of safeguarding referrals and DATIX recording, to identify any concerns or emerging themes specifically in regards to inappropriate referrals, gaps in reporting concerns and to review screening out decisions.

Monthly governance reporting was evidenced through the DAPO's completion of quarterly checks and audits of ASG records. ASG was a standing item on the ward Daily Safety brief. This is used during staff handovers to update staff in relation to required protective measures or changes for each patient. Staff demonstrated knowledge of protection measures in place for patients.

5.2.3 Patient Experience

Responses from patients regarding their experiences of care and treatment were in the main positive, and staff were observed to be delivering compassionate care.

The current operation of the ward was noted to impact upon patient experience as they were unable to move freely between ward areas without staff supervision; patients spent time within their allocated personal day space or on planned activities off ward when available.

It was noted through observation and from speaking with staff, that there was a limited range of activities available to patients. While staff were observed to spend time engaging with patient's in their personal day spaces there was limited activity and therapeutic opportunities on offer.

The Trust should consider the development of activity schedules to guide staff in their work with patients, to promote meaningful engagement and enhance patient outcomes. Activity planning should be informed by the patient's assessed need and preferences and all staff should be involved in the implementation.

A number of patients were on a modified diet; this was noted in patient care plans. Information was available in the ward kitchen and patient care records regarding the Speech and Language Therapy (SLT) advice for eating, drinking and swallowing needs. Mealtimes were aligned with the regional framework 'Mealtimes Matter' where a co-ordinator had oversight of mealtime on the ward.

Meals were served to patients within their personal day spaces, as they were unable to avail of the communal dining space. Whilst opportunity for social interaction with other patients was limited, staff were present and engaged during patient mealtimes.

The use of Talking Mats was in operation to encourage patient participation and obtain views where possible. Best practice actively involves patients in their care, where they are listened to and facilitated if possible to provide their views and opinions in relation to their care and treatment.

5.2.4 Physical Health

Patient records evidenced patient's physical health care needs and treatment. Routine physical health assessments, health monitoring and review of anti-psychotic medication were being undertaken. Regular assessments such as Skin bundles, Malnutrition Universal Screen Tool (MUST), falls risk assessment and moving and handling were in some instances not available, or in others not up to date.

A review of patient care plans indicated inconsistency, in some instances not all assessed needs had an associated care plan. The Trust should ensure that all patients who have assessed physical health care needs have a specific care plan in place, recording all needs, treatment and review plans. This is further referenced in section **5.2.10**
An area for improvement has been identified in relation to care plans.

Staff discussions reflected awareness and consideration of patient's experience of pain. It is recommended that the Trust further explores the use of Pain Assessment Tools, to ensure patients who experience pain are better understood by having their pain recognised and managed whilst reducing, distress and promoting patient wellbeing.

5.2.5 Medicines Management

Medication kardexes were available on Encompass and there was a robust system in place for ensuring each patient was receiving their correct medications. The treatment room was observed to be neat, tidy and well ordered.

Carrick 2 has pharmacy provision which is shared across the Holywell site. The pharmacist provides advice, support, provision of information and guidance in regards to specific patient matters or queries from staff. Pharmacy staff conduct regular review of Kardexes and "when required" medication.

Feedback from pharmacy, medical and nursing staff reported a reduction in "when required" medication usage over recent months. Records evidenced that first, second and third line medication was clearly documented on Encompass and administered in line with patient prescription.

5.2.6 Restrictive Practice

The Regional Policy on the use of Restrictive Practices in Health and Social Care Settings, Department of Health, November 2023 (Regional Policy), provides the framework to integrate best practice in the management of restrictive interventions, restraint and seclusion. The regional policy should be implemented in conjunction with the routine use of Three Steps to Positive Practice, The Royal College of Nursing, to ensure that the use of any restrictive intervention is rights based, used as a last resort and has been determined to be the least restrictive.

Restrictive practices in use within Carrick 2 included locked doors to manage entry to and exit from the ward, use of medicines prescribed on a 'when required' basis, the levels of patient observations and the use of physical interventions.

Restrictive practices in place for each patient had been risk assessed, the impact upon the patient from a Human Rights perspective was considered, and there was a documented rationale for each restriction which had been applied in line with the Regional Policy. Restrictive practices were reviewed as part of MDT weekly meetings with reduction planning agreed where possible; active measures were in place to reduce restrictions.

Concerns were identified and discussed with staff regarding the restricted operation of the ward, measures had been implemented by the Trust on a temporary basis, following consideration of individual needs of patients. Access for patients to communal dining and living spaces was limited, and these spaces were not being used in the way they were intended.
Due to these restrictions, the ward is not currently offering a full range of activities and therefore the therapeutic operation of the ward is reduced.

The Trust should give further consideration to managing risks and patient safety whilst promoting opportunity for meaningful patient engagement and the use of ward spaces to promote recovery and patient outcomes. In regard to restrictions the Trust should ensure these are the least restrictive, there is a process of continual review and a clear rationale is evidenced whilst the restriction remains in place.

5.2.7 Mental Health

Patients admitted to Carrick 2 may be detained under the Mental Health (Northern Ireland) Order 1986 (MHO). Patient documentation was up to date with all relevant prescribed forms in place regarding the patient's detention.

Patients who required safeguards under the Mental Capacity Act (NI) 2016 (MCA) may be subject to Deprivation of Liberty Safeguards (DOLs) and this was evidenced within patient records. Staff demonstrated understanding and knowledge of both MHO and MCA (DOLs) legislations and the implications for patients and delivery of care.

A mental health assessment is completed upon admission and patient mental health is discussed with staff at daily safety brief. Risk screening tools were completed for all patients and where required, comprehensive risk assessments were in place and had been updated. There was clear evidence of MDT contribution and review of patient's care documented in the Trust's electronic recording system.

Care and treatment was being delivered holistically and evidenced strategies for intervention and recovery were documented within patient care plans, however on review some of these require further attention to ensure that they are not generic and accurately reflect patient's individual mental health care needs. An Area for Improvement has been identified in relation to care plans.

A number of patients had Positive Behaviour Support plans (PBS), these are individual plans which assist staff understanding of patient behaviour and support change. Plans reviewed were individualised and comprehensive containing intervention strategies using the traffic light system, and detailed strategies for staff to support patients develop effective communication.

The Trust had commenced a review of the implementation of the plans with support from the Behaviour Support Specialist. The purpose of this review was to promote and enhance staff understanding of individual communication needs of patients, their behaviours and ensure person centred interventions. Staff were receptive to the implementation of PBS strategies and welcomed guidance and advice provided from PBS specialist staff. The Trust had a process in place for staff to confirm their review of PBS plans.

As part of the review arrangements the Trust should ensure that PBS plans are reviewed on an ongoing basis and updated to reflect change. This will ensure that staff are appropriately equipped with the knowledge and understanding of changing patient need and effective strategies to reduce distress.

5.2.8 Staffing

All inpatient wards are required to have safe staffing levels, which means having the right number of staff with the right skills and experience to provide high quality care to patients. Carrick 2 determines safe staffing arrangements using the Telford Model, a tool used to assist staff in ensuring appropriate staffing levels are met, based on patient acuity. On review of staffing rotas and from observations safe staffing levels were being met.

Carrick 2 is staffed by a mix of substantive and agency Learning Disability nurses and other Allied Health Professionals (AHP). Across the staff team there was a wide range of professional experience including newly qualified nurses. A number of agency staff were consistently booked in advance to ensure safe staffing levels and this is beneficial for continuity of care for patients.

All staff undergo training specific to their role working with patients to include Safety Intervention (SI). Staff training records indicated staff were compliant with mandatory training and where required had undertaken SI to the required level to meet the specific needs of individual patients.

Carrick 2 has a complement of multi-disciplinary team (MDT) staff to include, Psychiatry, Speech and Language Therapists, Occupational Therapists, Social Workers, Safety Intervention and Behaviour Specialist staff who work varied dedicated hours to contribute to patient care.

During the inspection a range of staff from both nursing and MDT complements reported collaborative and strong team working to care for patients. The absence of a dedicated Psychology Service however meant patients in need of psychology based treatment were not having all of their needs addressed. The availability of psychology is a necessary component of the MDT as described within the National Institute for Health and Care Excellence (NICE) guideline [NG54]. The availability of psychology would enhance the delivery of care and treatment and support improved outcomes for patients. The Trust should review patient access to psychology and determine if a dedicated resource is required for Carrick 2.
An Area for Improvement has been made.

Staff expressed there was good support available from within the core staff team and from line managers, and while there was a mixed response in regard to SMT visibility on the ward, all staff reported good SMT availability for support if required. Staff presented as passionate about their role and demonstrated compassion for patients they were caring for with positive morale among the staff team.

5.2.9 Patient Flow

Some patients were delayed in their discharge. The system in place to monitor patient flow within Carrick 2 included daily review and reporting of data at Senior Management Level across the Holywell Hospital site.
Carrick 2's operational policy sets out, that upon admission a provisional date for discharge of the patient should be identified, and the Trust should continue to maintain a focus on discharge progress from the point of admission, involving patients and their carers.

Patient care records acknowledged the discharge process at the point of admission and during weekly discussion at MDT meetings, however active discharge planning processes could not commence until a suitable community placement had been identified. There was evidence of carer involvement in discharge planning discussions.

The ward operates a monthly 'touch-point' discharge meeting to engage key staff involved in discharge planning arrangements from other Trust areas. This was reported to be successful and was intended to continue to remain in place as a means of ensuring key staff were present and relevant information was discussed.

5.2.10 Governance

Governance arrangements were reviewed through examination of relevant documents, discussions with the ward manager, SMT and a range of staff across the MDT.

There was oversight at all levels of management with clear focus on critical and emerging issues. There was an established process for escalation, and review of documents clearly demonstrated that this process was effective, and there was evidence of action planning in response to matters escalated regarding incident management, adult safeguarding and staffing.

Patient care planning records and documentation requires review, to ensure that all patient's care plans are comprehensive, individualised and in place for each assessed need identified. It is suggested that the areas for focus should include, mental health, physical health and personal care. Once the implementation of Encompass is completed the Trust should take steps to ensure that there are arrangements for review of care plans in line with the relevant area for improvement.

Complaints regarding the care provided within Carrick 2 were managed at ward level and maintained in a hand-written format with limited information to outline the steps taken. The Trust centralised complaints process was not evident from the records reviewed. It is recommended the Trust review the localised process in place. This has been identified as an area for improvement.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006)

	Standards
Total number of Areas for Improvement	4

The total number of areas for improvement are four, all have been stated for the first time.

Areas for improvement and details of the Quality Improvement Plan were discussed with the ward manager and other key senior staff of the Carrick 2 team Position as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan	
Action required to ensure compliance with Quality Standards for Health and Social Care DHSSPSNI (March 2006)	
Area for improvement 1 **Ref:** Standard 5.3.1 *(a,f)* Standard 5.3.3 *(b)* **Stated:** First time **To be completed by:** 01 April 2025	The Northern Health and Social Care Trust should ensure that patients have comprehensive and individualised care plans in place to address all assessed needs, this should include the areas of physical health, mental health and personal care. All care plans should be kept under regular review. Ref: 5.2.4 and 5.2.10
	Response by registered person detailing the actions taken: All care plans have had a comprehensive review to address individual assessed need to include physical, mental health and personal care. Care plans are reviewed based on assessed need and are accessible on Encompass.
Area for improvement **Ref:** Standard 5.3.2 *(a)* **Stated:** First time **To be completed by:** 01 April 2025	The Northern Health and Social Care Trust should ensure that Ligature Risk Assessments are reviewed when required and at least annually. The Trust should ensure that action plans associated with fire and ligature risks are completed in line with the identified timescales, and that records are maintained and updated to reflect actions taken and progress made. Ref: 5.2.1
	Response by registered person detailing the actions taken: Carrick 2 ligature risk assessment is reviewed annually or sooner if there is a change in risk . The Ligature risk

	assessment identifies timescales and all records are maintained to reflect the actions and progress made and are readily available on the ward. Fire risk assessments and associated manual have been updated in line with the NHSCT policy and are also accesible on the ward.
Area for improvement 3 **Ref:** Standard 6.3.1 *(c)* **Stated:** First time **To be completed by:** 01 June 2025	The Northern Health and Social Care Trust should review patient access to psychology services and determine if a dedicated psychology resource is required. Ref: 5.2.8
	Response by registered person detailing the actions taken: Carrick 2 is not currently funded for dedicated Clinical Psychology provision. If a patient is assessed as requiring psychological intervention, a referral can be made to Community Learning Disability Clinical Psychology or Community Treatment Services (PBSS/Promote) as part of discharge planning process. Consideration for the need for a dedicated service is underway with the Assistant Director and Consultant Clinical Psychologist and Head of Service for Carrick 2.
Area for improvement 4 **Ref:** Standard 8.1.3 *(k)* **Stated:** First time **To be completed by:** 01 April 2025	The Northern Health and Social Care Trust should review the localised complaints process and relevant governance arrangements. Ref: 5.2.10
	Response by registered person detailing the actions taken: The Northern Health and Social Care Trust is currently reviewing the complaints process to include the localised complaints.

Please ensure this document is completed in full and returned via the Web Portal

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