The Regulation and Quality Improvement Authority

MENTAL HEALTH AND LEARNING DISABILITY

ANNOUNCED INSPECTION

Cranfield ICU, Muckamore Abbey Hospital

Belfast Health and Social Care Trust

29 June 2012

informing and improving health and social care
www.rqia.org.uk

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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.

On 24 October 2011 RQIA informed the Belfast Health and Social Care Trust of the inspection date and forwarded the associated inspection documentation. RQIA adopted the approach of self-assessment, which allowed the ward the opportunity to demonstrate its ability to deliver a service against best practice indicators. This included the assessment of the trust's performance against an RQIA compliance scale, as outlined in Section 6.

The inspection process included an analysis of the ward's self-assessment, other associated information, discussions with ward staff, patients and relatives. A range of multidisciplinary records, policies and procedures were also examined as part of the inspection.

The recommendations made during the previous inspection on 21 June 2011 were also assessed during this inspection to determine the trust's progress towards compliance. Several recommendations were taken forward but a previously stated recommendation that is outstanding has been added to the quality improvement plan for action (reference Appendix 1)

An overall summary of the ward's performance against the human rights theme of protection is in Section 3 and full details of the inspection findings are outlined in Appendix 2.

2.0 Ward Profile

Trust	Belfast Health and Social Care Trust
Name of hospital/facility	Muckamore Abbey Hospital
Address	1 Abbey Road Antrim BT41 4SH
Telephone number	028 94 463333
Person in charge on day of inspection	Damian O'Kane
Nature of service - MH/LD	LD
Name of ward/s and category of care	Cranfield ICU
Number of patients and occupancy level on days of inspection	7
Number of detained patients on days of inspection	6
Date of last inspection	21 June 2011
Name of Inspector	Margaret Cullen

Cranfield Intensive Care Unit (ICU) Muckamore Abbey Hospital is a purpose built single storey facility which provides intensive care and support to adults with a learning disability. The unit is located within the same building as the Cranfield Male and Female admission wards and all three facilities share a spacious and welcoming reception area which is staffed on a full time basis.

The ICU can be accessed via either of the admission wards and has an additional separate entrance to the rear.

Access to the unit is controlled by staff who use a swipe card and at the main entrance there is a large activity room and a visitors' room. The unit's kitchen and utility areas are off the main entrance. The patients' accommodation is through a further set of locked doors

The unit has a large communal area which is furnished with a range of seating, dining furniture and a TV which is housed within a protective storage cabinet. The communal area also has a clinical room and nurses station, behind which is the office.

There are three rooms and a patients' toilet off the main communal area and two of the rooms have TV's and a range of seating. One room contains soft chairs and a table. The unit has a kitchen which is accessed only by staff and patients are served their meals from the kitchen servery.

The unit provides single room mixed gender accommodation and all bedrooms have en suite facilities and built in storage space. One of the bedrooms is larger than the others and is fully accessible for wheelchair users.

The unit has access to a seclusion area, which is located just off the main communal area. The seclusion area consists of a seclusion room with an adjoining bathroom.

The unit's rear entrance is located within this area of the unit and the seclusion facilities are available to patients across the hospital site.

Patients have access to an enclosed garden area which is partially sheltered by the unit's roof. This area is the patient's designated smoking area.

3.0 Inspection Summary

The purpose of this inspection was to assess the ward's procedures and arrangements for safeguarding vulnerable adults. Inspectors did this by speaking with patients, staff, an advocate and visiting professionals**.** A range of multidisciplinary records, policies and procedures were also examined. A detailed analysis of the arrangements for safeguarding vulnerable adults in Cranfield ICU was undertaken and is outlined in full in Appendix 3.

The inspection was announced and took place on 29 June 2012 by Margaret Cullen and Patrick Convery**.** However a pre-inspection visit took place on 17 January 2012 and information was also collated during this visit. The ward manager had prepared some self assessment information prior to the inspection and distributed a number of questionnaires to patients, their relatives, staff and visiting professionals.

This inspection focused on the human rights theme of protection which included a focus on the safeguarding of vulnerable adults in Cranfield ICU Ward, Muckamore Abbey Hospital.

There were a number of recommendations made during the previous inspection in June 2011 and the ward's progress towards compliance with these was assessed (Appendix 1). While a number of recommendations are restated it was noted that good progress was made in relation to:

- documentation of multidisciplinary Team (MDT) discussion on restrictive practices.
- enhanced provision of advocacy services.
- incident and VA1 documentation appropriately referenced in the notes examined.
- enhanced access for patients to the responsible medical officer
- clear assessment and care planning documentation noted

Inspectors noted the high level of challenging behaviour on the ward in relation to the patient profile and acknowledged the commitment of staff who related that they felt safe on the ward due to mutual support and supportive management. Patients also indicated that they felt safe and that they were treated well despite the need for restrictive practices.

Most of the staff have been trained in the safeguarding vulnerable adults procedures and those who have not been trained have been scheduled for future training. Staff reported that they felt competent in their requirements to safeguard and the policy and procedures and reference guide were easily accessible. It was recommended that the training is completed for all staff.

Inspectors noted a wide range of additional supporting policies and procedures available for staff as well as risk assessments, care plans and reviews appropriately documented. Patients' notes indicated that vulnerable adult referrals and processes were also appropriate. It was recommended that forms are completed in legible writing or typed.

Staff are provided with a corporate and ward induction programme. It was recommended that safeguarding is included in all induction processes. Appraisal and supervision are provided for all staff and the ward manager confirmed that training needs discussion are integral to both. Staff stated that they are facilitated to access training. Electronic and manual systems record training achieved and future requirements. It was recommended that mandatory training is reviewed as gaps were noted on examination of these records. It was also recommended that training in child protection is extended to all staff.

Inspectors examined the recording mechanisms for restrictive practices; seclusion, restraint and observation. The notes indicated that these were reviewed appropriately and documented in the care plans. The hospital has been commended in the training and audit of physical restraint by the British Institute for Learning Disabiity (BILD). Good practice was identified in relation to recording, training and monitoring of this. Seclusion records were examined and reflected trust policy. Observation needs were clearly documented and reviewed. A recommendation was made in relation to consideration of the DHSSPS interim guidance on deprivation of liberty, October 2010.

There was evidence that patients and relatives are provided with information in relation to complaints and what to expect in relation to their care. The welcome booklet with additional leaflets reflected good practice. Inclusivity was also noted in relation to visiting arrangements, and the level of contact with family evidenced in the notes. However, a recommendation was made to consistently inform relatives about incidents and vulnerable adult referrals to ascertain and record their views. A recommendation was made to inform patients and relatives about their right to access information held about them. Patient forums are held to involve patients on the ward but it was noted that attendance is sporadic and the advocate is not present. Recommendations were made in relation to this.

Patients have the opportunity to take positive risks in relation to the overall management of risk. Zero tolerance in relation to abusive behavour is clearly indicated on the ward. It was recommended that a code of behaviour is specifically adopted.

Inspectors reviewed the processes in place to safeguard patients' finances and personal property. Inspectors concluded that staff endeavoured to adhere to the Trust's policy. Patients' capacity is assessed at the first MDT review and actions put in place according to identified need. A recommendation was made to include records of small amounts of money used when there were no receipts available. Safeguards are also in place to secure belongings and staff related that single lockable rooms assist in this regard.

The ward fully complies with the DHSSPS requirements for the admission of under 18 year olds to adult wards.

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

4.0 Stakeholder Engagement

Questionnaires were issued to staff, patients, relatives, carers and visiting professionals in advance of the inspection. The responses from the questionnaires were used to inform the inspection process.

Questionnaires issued to	Number issued	Number returned
Patients	**7**	**3**
Carers/Relatives	**7**	**0**
Visiting Professional	**5**	**4**
Staff	**10**	**2**

During the inspection the inspector has the opportunity to meet with staff, patients, relatives/ carers, visiting professionals or advocates. Below are the details of the number of discussions held during the inspection.

Additional discussions during inspection	Number
Patients	**4**
Carers/Relatives	**0**
Visiting Professionals	**1**
Staff	**6**
Advocates	**1**

Stakeholder Participation:

Patients

Patients interviewed and from the questionnaires stated that they understood that staff had a responsibility to keep them safe. Most patients indicated they were aware of their risk assessments though not all felt involved in it. Patients also indicated that they had been helped to keep safe and those that referred to restrictive practices stated that it had been explained to them. Most patients were also aware of the Safeguarding Vulnerable Adults policy. Not all patients were aware of the complaints procedure. Some patients stated that they had felt upset or distressed on the ward and examples given were being shouted at and being struck or having hair pulled. They indicated that they would tell staff and be reassured or given one to one care. There were no concerns expressed about the safety of their money but a few patients suggested they were worried about personal items being broken or going missing. They indicated that staff were helpful and suggestions for improvement included:

“Could be quieter”

“More activities at weekends”

Staff

Staff interviewed indicated that they were aware of safeguarding procedures and most had training, the two staff who completed questionnaires had not received training but were keen to do so.

Staff confirmed that they were aware of risk assessment and incident reporting but did not all indicate that they received training, however, the questionnaires did not specify the grade of staff. Some of the staff stated that they did not receive annual appraisal. All staff were aware of the arrangements to protect patients’ monies and property. Staff both in interview and questionnaires stated that there was “good morale on the ward”, “good staff team”, “good staff relations”.

Advocate

An inspector met the advocate on a pre-inspection visit to the ward and was informed that patients are referred on admission. Inequity of access to avocates was referenced in relation to patients from the Western Trust as the service was not commissioned for them by the trust. However, during the inspection the ward manager informed inspectors that this had been resolved.

Visiting professionals

The visiting professionals all indicated full understanding and awareness of the safeguarding responsibilities. They all confirmed good working relations on the ward and positive communication systems. All but social work professionals record in patients’ notes on the ward. Responses were very positive but not all professionals were aware of the ward’s code of behaviour.

Positive comments made included:

- “staff are committed to providing good quality care”
- the appointment of a Deputy Manager has improved patient care”
- “very individual approach to care”
- “good balance between risk and restriction based on forensic need”

Improvements suggested included:

- “Progression of effective review system”.
- “Progression of patient involvement in reviews and planning and risk management forum”
- “Enhancing therapeutic environment through groups”
- “Separate ICU units for male and female patients”

5.0 Additional Concerns Noted by Inspectors

- The inspection ended on Friday evening and inspectors were informed of a patient being transferred from another ward later that day. Discussions with staff indicated concerns about the appropriateness of some of the admissions and that there can be over occupancy on occasions. It was emphasised that many crisis admissions occur on Friday evenings and on weekends. Inspectors asked that an audit is kept of any urgent assessments/admissions requested over a weekend period and their perceived appropriateness by the MDT and records of over occupancy. It was recommended that a policy/ guidance document regarding bed management to the ward is required.

- Inspectors were concerned about the gender and diagnostic mix on the ward or patients requiring specialist care, which impacted on the overall care and safety of patients on the ward. Staff confirmed the difficulties compounded by a mixed gender ward and it is requested that the impact of these issues is monitored and assessed over the next six month and a report furnished to RQIA by March 2013.

- Inspectors were informed that despite efforts from staff and a structured timetable located on the ward, patients find the weekends long, with few activities. It is recommended that this is kept under review at the patient forum meetings.

- Patients informed an inspector that the quality of food on the ward is poor and this was concurred by staff. The ward manager agreed to continue in their efforts to improve matters.

- Inspectors were advised that there is now equity in access to advocacy services as there had been previous problems in patients from the Western Trust having this service provided. However, inspectors did not see evidence of the proactive involvement of advocacy services and asked that this is reviewed.

- Discussion with the ward consultant and ward manager highlighted the difficulties in accessing extra contractual referrals (ECRs) for specialist treatment. An example of gender discrimination was also referenced in relation to a female patient requiring a forensic bed. Male patients can access Sixmile Forensic Unit on site, whereas female patients have to be referred outside the jurisdiction. The time delay in accessing funding for ECRs is considerable and RQIA wish to be kept informed of any future delays.

- An inspector noted that records of MDT discussion are maintained separately in medical and nursing files. There is no consistent way of recording and some records were very brief. It was recommended that a template is considered to fully evidence issues discussed, stakeholders present and actions planned and outcome updates.

6.0 Compliance Scale

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.

7.0 Summary of Compliance – RQIA Assessment

NO	Question	Compliant	Substantially Compliant	Moving Towards Compliance	Not compliant	Not Applicable
1	How do you ensure that everyone involved with the ward is aware of and understands the safeguarding vulnerable adult policy?		✓			
2	List the additional procedures and guidelines that you use to support the safeguarding vulnerable adult policy.	✓				
3	List the additional procedures and guidelines, aimed at promoting safe and healthy working practices, which you use to support the safeguarding vulnerable adult policy.		✓			
4	Outline how the ward is involved in the review of the Trust's safeguarding vulnerable adult policy, the code of behaviour and the other associated procedures and guidelines.		✓			
5	Outline how new staff are appropriately inducted into the ward.			✓		
6	Describe how staff training needs, appropriate to the post/ role, are identified.		✓			
7	Outline the arrangements in place for: (i) the support and supervision of all staff (ii) the annual appraisal of staff and the review of volunteers		✓			
8	Describe the arrangements in place for maintaining written records of: training completed; support and supervision; and annual appraisals and reviews.		✓			
9	Describe how the ward ensures staff and volunteers comply with the Safeguarding Vulnerable Adults Standard 4.	✓				
10	Outline the steps the ward has taken to ensure that staff and volunteers are competent to recognise signs of abuse.	✓				
11	Describe how the ward identifies and manages risks for individual patients.		✓			
12	Outline the mechanisms used by the ward to ensure that vulnerable adults have the right to take risks in relation to their care.	✓				
13	Describe how the reporting, recording and reviewing accidents, incidents and near misses informs and influences ward practice and the risk assessment and management procedures.	✓				

14	Describe how the ward promotes and communicates the Trust's 'ethos of inclusion, transparency and openness' to vulnerable adults, carers, advocates, family members, staff and volunteers.		✓			
15	Describe the procedures in place for carers, advocates and vulnerable adults to share concerns they may have or to make complaints about the organisation.	✓				
16	Outline the steps the ward has taken to encourage carers, advocates and vulnerable adults to raise concerns or make a complaint following an incident.			✓		
17	Outline how the ward ensures that staff know and comply with the records management policy.		✓			
18	Outline the mechanisms the trust has in place to inform vulnerable adults about their right to access to information held about them.				✓	
19	Describe how the ward ensures that staff, volunteers and visitors know about and adhere to the Code of Behaviour.			✓		
20	outline how the ward safeguards patients' rights in relation to the use of: (i) restrictions on the ward (ii) isolation/ seclusion (iii) close observation (iv) restraint		✓			
21	Outline the mechanisms for the handling of vulnerable adults' money.		✓			
22	Outline how the ward ensures the safety of patients' property while on the ward.		✓			
23	Describe what arrangements the ward has in place for children visiting the ward.			✓		
24	Outline the safeguarding arrangements the ward has in place for the admission of an under 18 year old.	✓				

Appendix 1 – Quality Improvement Plan

QUALITY IMPROVEMENT PLAN

ANNOUNCED INSPECTION

Cranfield ICU, Muckamore Abbey Hospital

29 June 2012

The issue(s) identified during this inspection are detailed in the quality improvement plan.

The details of the quality improvement plan were discussed with the ward manager and deputy ward manager

RECOMMENDATIONS RESTATED FROM PREVIOUS INSPECTION

NO.	RECOMMENDATION	NUMBER OF TIMES STATED	TIMESCALE (e.g. dd/mm/yy)
1	It is recommended that a template is considered to evidence compliance with the fairness standards.	1	30 November 2012

RECOMMENDATIONS MADE FOLLOWING INSPECTION OF SAFEGUARDING VULNERABLE ADULTS AND CHILDREN – HUMAN RIGHTS THEME OF PROTECTION

NO	AREA FOR QUALITY IMPROVEMENT	RECOMMENDATION	DETAILS OF ACTION TO BE TAKEN	TIMESCALE
1	**Staff induction, training, supervision and appraisal.**	It is recommended that all staff are trained in vulnerable adult processes by the end of 2012. It is recommended that the vulnerable adults procedure is included in all induction programmes. It is recommended that gaps in staff training are reviewed and resolved and that all training options are considered. It is recommended that action plans following supervision are recorded, agreed and monitored.	Training is ongoing - all staff will have completed training by end December. The induction booklet has been revised to include the vulnerable adults procedure. A Nurse Development lead (NDL) has been appointed, he is taking responsibility for all training needs and analysis, the ward manager has also completed a training needs analysis in the ward to identify and	**31 December 2012** **Immediate and ongoing**

			address deficits in mandatory training. Formal supervision is provided for all staff through the Peronal Contribution Plans. A timetable has been developed with supervision dates for all staff. Professional supervision is provided as per Trust policy. A template is completed following supervision which includes an agreed action plan, this is monitored.	
2	**Awareness and implementation of procedures for the protection of vulnerable adults.**	It is recommended that all reporting is legible. It is recommended that the vulnerable adults documentation has a field which evidences informing relatives.	Legibility has been addressed with staff, this is also audited through the EQC audit. The vulnerable adult documentation is in the process of being reviewed. It has been recommended that this field is added. At present	**Immediate and on-going** **30 November 2012**

			staff include this information on page 3 of the VA1 form and in the patients care plan. ✓	
3	**Incident reporting, risk management.**	It is recommended that the siging off and review of risk asessments are monitored. It is recommended that there is consistency in informing relatives of incidents. It is recommended to record capacity and/or checking out patient views post incident in relation to potential issues/ complaints. It is recommended that leaflets are developed to inform patients and their relatives of their right to access information held about them. It is recommended that the generic guidance on conduct is developed to reflect the arrangements in relation to behaviour within Cranfield ICU ward. It is recommended that the need to implement DOLs interim guidance, DHSSPS, 2010 is considered in relation to certain restrictions.	A bi monthly audit of risk assessments for new admissions takes place in the hospital, this audit includes reviews and signatures. Risk assessments are reviewed at the MDT meeting when there is a change in the risk as per PQC guidance. Relatives are informed following incidents, this is recorded under 'action taken' on Datix. ✓ Capacity is discussed by MDT and recorded in the patients notes, if applicable a post incident	**Immediate and on-going** **31 December 2012** **Immediate and ongoing**

			interview takes place with the patient and outcomes recorded in the patients care plan. All individuals have a right of access to personal information held about them by the Belfast health & Social care Trust, this is in accordance with principle 6 of the Data Protection Act. Staff are aware of the guidelines for processing requests for access to patient/client and personal records. Discussions are ongoing with Speech and Language Therapy re easy read leaflets to inform patients and their relatives of their right to access information held about them. Leaflets are available in the ward	

			about patients rights to confidentiality All professional staff groups have their own Code of Behaviour. All staff have a contract which includes a code of behaviour. Customer Care Standards are available in the ward. EQC monitors a number of standards in relation to behaviour. The Safeguarding Vulnerable Adults, A Shared Responsibility - Standards and Guidance for Good Practice in Safeguarding Vulnerable Adults January 2011 documentation is available in the ward. DOLs interim guidance, DHSSPS, 2010 is	

			implemented in the ward	
4	**Code of behaviour, patients' rights.**	It is recommended that the role and function of patient forum meetings are clarified and that the advocate attends to enhance transparency.	The role and function of patient forum meetings have been added to the patients welcome pack. Agendas, minutes and actions are displayed on notice board. Advocates are invited to meetings.	**31 December 2012**

5	**Patients' money and property**	It is recommended that in order to fully meet their reconciliation process that small purchases, where there are no receipts, are recorded consistently and countersigned where possible. It is recommended that patients are asked at forum meetings to report potential missing items and this is monitored.	Staff follow the guidance detailed in the document Patient's/Client's Private Property – Written procedures for Long Stay Patients/Clients. This is currently being updated to reflect issues raised by both RQIA and internal audit. Patients are encouraged to report missing items as soon as they are noted.	**Immediate and on-going**

6	**Other recommendations** BF.	• It is recommended that a policy/ guidance document regarding bed management to the ward is required. • It is requested that the impact the of the issues relating to the mixed gender ward is monitored and assessed over the next six month and a report furnished to RQIA. • It is recommended that activities on the ward are kept under review at the patient forum meetings. • It is recommended that efforts to improve the quality of food continues. • It is recommended that the proactive input of advocacy services are monitored. • It is requested that RQIA are kept informed of any future time delay in accessing funding for ECRs. • It is recommended that a MDT template is considered to fully evidence issues discussed, stakeholders present and actions planned and outcome updates.	The decision making process is multidisciplinary, and bed management decisions taken at the MDT Ward Round. All admissions or transfers are discussed with the ward Consultant during day time hours, and with the Consultant on Call out of hours. ✓ This report will be available by end March. Activites are a standing agenda item for discussion at the patients forum meetings. An activity timetable has been drawn up, detailing activities that are available and when they are available. Patients participation is recorded	**31 January 2013** **31 March 2013** **Immediate and ongoing** **Immediate and ongoing** **Immediate and ongoing** **Immediate and ongoing** **30 November 2012**

			in the patients care plan. PCSS staff attend patient forum meetings to discuss issues re menus and the quality of food, when invited. PCSS staff also attend Patient council meetings to discuss catering service. From this meeting the Patient council 2012 food survey template was created and sent out to wards, subsequently Food survey 2012 results report has been issued. A meeting has taken place with advocates to confirm their role and responsibility, once these have been defined this information will be available to all staff and patients. Input from advocates is recorded in the patients care plan. The Co-Director for Adult	

			Learning Disability services has written to each of the Trust's advising them of the Belfast Trust's requirement to Notify RQIA of any future delays in accessing ECR Funding. A record of the MDT meeting is included in the patients care plan, this includes details of those present, issues discussed, actions planned with outcome dates if known and person responsible for actioning. Once Paris is implemented, the notes will be multidisciplinary and this information will be captured electronically.	

The Quality Improvement Plan is to be signed by the Chief Executive and returned to:

Mental Health and Learning Disability Team
The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
Belfast
BT1 3BT

SIGNED: _____

NAME: C McNicholl

DATE: 12/11/12

FOR OFFICE USE ONLY:

QIP viewed by inspector on:

DATE: 11. 2 .13

SIGNED: _____

NAME: M CULLEN