Mental Health Inpatient Inspection Report
28 – 30 November 2016

Cranfield Ward 2

Muckamore Abbey Hospital
1 Abbey Road,
Muckamore,
BT41 4SH
Tel No: 02895 042063
Inspectors: Wendy McGregor, Dr Oscar Daly

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

Cranfield Ward 2 is a 15 bedded ward with an additional apartment that provides care and treatment to male patients with a learning disability who have an enduring mental illness, and complex behaviours that challenge.
On the days of the inspection there were 15 patients on the ward and 1 patient in the apartment. Two patients were detained appropriately and in accordance with the Mental Health (Northern Ireland) Order 1986.

3.0 Service Details

Responsible person: Michael McBride
Ward manager: Linda McCartney

4.0 Inspection Summary

An unannounced inspection of Cranfield Ward 2 took place over three days from 28 – 30 November 2016.

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 specific needs and choices.

We assessed if Cranfield ward 2 was delivering, safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in relation to the range of activities available both on and off the ward, patient and relative involvement in all aspects of care and treatment and the quality of the reporting and recording in patient's care documentation.

Patients said:

"The ward is good".

"I get on well with my named nurse".

"There are lots of things for me to do, I go to the gym and I go horse riding".

"I like going to Moyola (day-care)".

"We go out at the weekends".

"I am frustrated that there is nowhere for me to go to in the community".

"Being here has helped me but I am fed up waiting on a place in community".

"I should not be here as I am better…..I have been waiting on a placement in the community".

Although patients spoke highly about the care and treatment on the ward they expressed their continued frustration that their discharge was delayed. This meant that patients remained in a restricted environment which potentially had an impact on their human rights. Two patients also indicated that being in hospital was no longer helping and was having an impact on their mental health. 14 out of 16 patients on the ward were assessed as being ready for discharge. Of note the inspector had met some of the same patients during a previous inspection in January 2014.

RQIA has written to the HSCB in relation to the number of delayed discharges in the overall hospital site.

Relatives said:

"I find the staff caring and thoughtful".

"The staff have been very supportive and we appreciate all they do for X. We would like to see X going out more and joining in with recreational activities but he does not want to at the moment".

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	5

Findings of the inspection were discussed with ward staff; members form the multi-disciplinary team and senior trust representatives as part of the inspection process and can be found in the main body of the report.

5.0 How we Inspect

The inspection was underpinned by:

- The Mental Health (Northern Ireland) Order 1986
- The Quality Standards for Health & Social Care: Supporting Good Governance and Best Practice in the HPSS, 2006
- The Human Rights Act 1998
- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003
- Optional Protocol to the Convention Against Torture (OPCAT) 2002

Prior to inspection we review a range of information relevant to the service. This included the following records:

- The operational policy or statement of purpose for the ward.
- Incidents and accidents.
- Safeguarding vulnerable adults.
- Complaints.
- Health and safety assessments and associated action plans.
- Information in relation to governance, meetings, organisational management, structure and lines of accountability.
- Details of supervision and appraisal records.
- Policies and procedures.

During the inspection the inspector met with eight patients, nine members of the multi-disciplinary team and estates staff and received questionnaire feedback from two relatives.

The following records were examined during the inspection:

- Care documentation in relation to four patients.
- Medication Prescription and Administration Records.
- Emergency equipment records.
- Staff rota.
- Training records.
- Patient forum minutes.
- Mental Health Service Group Information Dashboard June 2016.
- Medication governance review.
- Staff meeting minutes.
- Financial records.
- Monthly Quality monitoring report.
- Ward incident analysis.
- Fire evacuation procedure.
- Care plan audit records.
- Learning board
- Activity timetable

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

We reviewed recommendations made at the last inspection. An assessment of compliance was recorded as met.

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

6.0 The Inspection

The most recent inspection of Cranfield Ward 2 was an unannounced type inspection. The completed Quality Improvement Plan (QIP) was returned and approved by the responsible inspector. This QIP was validated by the inspector during this inspection.

6.1 Review of Recommendations from Last Inspection dated 24/04/2015

The responsible person must ensure that following recommendations were addressed.

Recommendations		Validation of Compliance
Recommendation 1 **Ref**: Standard 5.3.1(a) **Stated:** Third Time	It is recommended that the ward manager ensures all comprehensive risk assessments are reviewed in keeping with regional guidelines.	**Met**
	Action taken as confirmed during the inspection: The inspector reviewed comprehensive risk assessments in relation to four patients. All risk assessments were reviewed and up to date in keeping with regional guidelines.	
Recommendation 2 **Ref**: Standard 5.3.1 (f) **Stated:** Third Time	It is recommended the ward manager ensures that staff complete documentation in line with published professional guidance on record keeping.	**Met**
	Action taken as confirmed during the inspection: The inspector reviewed the care documentation in relation to four patients. Care documentation was completed in line with professional guidance in relation to record keeping.	

Recommendation 3 **Ref**: Standard 5.3.3(b) **Stated:** Second Time	It is recommended that the Ward Manager ensures that risk screening tools are completed in full. If a decision is made not to proceed to a full comprehensive risk assessment then a clear rationale must be recorded and signed by all relevant parties, as outlined in the Promoting Quality Care Guidance Document – Good Practice on the Assessment and Management of Risk in Mental Health and Learning Disability Services- May 2010.	**Met**
	Action taken as confirmed during the inspection: The inspector reviewed risk assessment documentation in relation to four patients. Each patient had a risk screening tool completed in full. It was noted that all patients had a comprehensive risk assessment completed in accordance with the Promoting Quality Care Guidance Document – Good Practice on the Assessment and Management of Risk in Mental Health and Learning Disability Services- May 2010.	
Recommendation 4 **Ref**: Standard 6.3.2 **Stated:** Third Time	It is recommended the ward manager ensures the care plans in relation to actual or perceived deprivation of liberty are reviewed to include evidence of proactive strategies considered to reduce the restriction.	**Met**
	Action taken as confirmed during the inspection: The inspector reviewed care plans in relation to four patients. Each patient had a care plan in place that addressed the actual or perceived deprivation of liberty. These were noted to be reviewed and up to date and included proactive strategies to be considered to reduce the restriction.	

Recommendation 5 **Ref**: Standard 6.3.2 **Stated:** Third Time	It is recommended the ward manager ensures that care plans in relation to actual or perceived deprivation of liberty are reviewed to ensure that the rationale and therapeutic aim is included in the relevant care plan.	**Met**
	Action taken as confirmed during the inspection: The inspector reviewed care plans in relation to four patients. Each patient had a care plan in that addressed the actual or perceived deprivation of liberty. The inspector noted that each care plan included the rationale and therapeutic aim in relation to the restriction. The inspector noted that the behaviour support team were actively involved on the ward.	

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

Risk screening tools, risk assessments and management plans were in place for each patient. These were noted to be completed in accordance with Promoting Quality Care Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Service May 2010 (PQC). There was evidence that patients and their next of kin were involved in their risk assessments and management plans.

There was an up to date ligature risk assessment completed on 9 August 2016. The ward was assessed as having a small number of ligature points, most of these areas were only accessed by staff, there were ligature points identified in two bedrooms, patients using these bedrooms were assessed as being at low risk from self-harm.

There was an up to date fire risk assessment and action plan completed on 10 November 2016. The fire evacuation procedure was up to date completed on 12 October 2016. There were 17 staff trained as fire wardens.

There was an up to date environmental risk assessment and action plan in place completed in relation to Cranfield Ward 2.

All staff interviewed knew who to raise concerns in relation to safety.

All staff confirmed that they have never been asked to work beyond their role, experience or training.

Nursing staff stated they received a good hand over during shift change which included any risks on the ward.

Nursing staff were visible on the ward during the days of the inspection.

There were two patients on the ward who were detained in accordance with the Mental Health (Northern Ireland) Order 1986. Both patients had an appropriate detention care plan that detailed the safeguarding measures that were in place.

Staff actively sought consent prior to care and treatment delivery.

The inspector observed an incident during the second day of the inspection. A patient became physically unwell. The incident was observed to be managed safely and staff sought prompt

medical advice. The ward doctor arrived promptly and emergency services were also appropriately contacted. Staff explained to the inspector the process they followed. Staff were organised and remained calm. The patient was supported to go to hospital by two staff from the ward.

All patients interviewed knew how to make a complaint. Information in relation to making a complaint was available via a variety of sources and in a format that met the needs of the patients that were on the ward during the inspection.

Areas for Improvement

Patient risk assessments and management plans.

Each comprehensive risk assessment and management plan was reviewed in accordance with PQC guidance. The information recorded in the review documentation was comprehensive and relevant however the review did not always reflect if the risk had reduced, remained the same or increased.

Financial capacity assessments.

One patient did not have their financial capacity assessment completed in full. Although it was recorded that the patient was assessed as incapable of managing their finances the relevant assessment scores were not completed to confirm the rationale for this decision.

Number of areas for improvement	2

7.2 Is Care Effective?

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

Areas of Good Practice

All care documentation was stored centrally on the patient electronic recording system (PARIS). All of the multi-disciplinary team were recording on the PARIS system.

Each patient reviewed had an up to date individualised comprehensive assessment of their needs in place.

Care plans were individualised and evidenced patient involvement. Patients also confirmed their involvement in care plans to the inspector.

There was a range of care and treatment options, from the multi-disciplinary team, which included psychology, behaviour support, occupational therapy (OT), medical and nursing.

There was a good range of structured recreational and therapeutic activities available both on and off the ward.

Each patient had an up to date assessment which addressed their nutrition and hydration needs. Care plans were in place to support patients who had difficulties with swallowing.

Patient's case conferences were held every two weeks. There were accurate and detailed records made. It was noted that these meetings were attended by the full multi-disciplinary team every two weeks. Agreed actions from the meeting were recorded and included the person responsible, and a time frame to meet the action. There was further evidence at the following meeting that the action had been achieved. This was also evidenced in each patient's progress notes.

Patients had access to timely assessments and interventions. It was noted that behaviour support staff attended the case conferences, which included patients that they were not directly involved with.

Nursing care plans were individualised, comprehensive and addressed each nursing need.

Each patient had a one to one meeting with their named or associate nurse. The records reviewed in relation to the one to one meeting were comprehensive. There was evidence that interaction during this meeting between patients and staff was person centred, personable and compassionate, and included how staff supported each patient with their communication. In addition to this all staff interviewed stated that one to one time enhanced the relationship between staff and patients and was used to support patients with their care plans.

The consultant psychiatrist met with each patient every week.

Medication kardexes were clearly written. Indications, maximum daily dosage and minimum intervals were recorded in relation to pro re nata (PRN) medication. PRN medication was noted to be used sparingly. Regular and PRN medication was prescribed in accordance with the British National Formulary (BNF). Medication was regularly reviewed. Regular reviews ensured that when PRN medication was not used it was discontinued.

Discharge planning commenced early. There was evidence of regular discharge planning meetings attended by community staff. The ward social worker liaised frequently with relatives and community staff to address issues in relation to patients whose discharge was delayed.

The ward social worker liaised frequently with relatives in relation to discharge planning.

The ward social worker proactively supported patients to maintain contact with their families.

The ward environment was enabling. Exit from the ward was not restricted. Patients had access to their bedrooms. The ward environment supported discreet supervision of patients. The environment was relaxed and comfortable and patients had access to quiet, private areas. Each patient had their own bedroom and en suite facilities.

Each patient reviewed had an individualised restrictive practice care plan in place. Staff interviewed were committed to avoiding the use of restrictive practices and when required used the least restrictive intervention. During the inspection there were five patients in receipt of enhanced observations. The documentation reviewed evidenced that the enhanced observations were necessary and proportionate to the risk and were regularly reviewed. The inspector reviewed the documentation in place in relation to one patient, who was assessed as requiring a restrictive intervention. The need for this intervention was clearly documented and evidenced that the restriction was necessary, proportionate to the risk and was reviewed every week by the multi-disciplinary team. There was evidence that consideration was given to the patient's human rights. The patient was accompanied by staff during waking hours, encouraged and offered the opportunity to socialise and mix with other patients and attended day time activities. Staff also supported the patient to maintain contact with their family. The inspector visited the patient. The patient had their own access in and out of their area. There were positive behaviour support plans in place which included a daily schedule and communication support plans. The area was spacious and included a bedroom with an en-suite, a sitting room and a dining room / activity room. The space was also noted to be person centred and was clean and tidy.

Areas for Improvement

<u>Speech and Language Therapy</u>

One patient who had a history of choking had a nursing care plan in place which included guidance from speech and language therapy (SALT). However the patient had not been reviewed by SALT since August 2015. This was addressed with the deputy ward manager during the inspection and an appointment was arranged for SALT to review the patient on Friday 2 December 2016.

Care plans

Goals were not consistently recorded in patient's care plans. It was noted that goals were documented as interventions and not specific to the assessed need. For example it was documented that one patient's mood fluctuates and the goal was to promote positive mental health. This would have made the effectiveness of this care plan difficult to measure.

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

All patients and relatives confirmed they were treated with dignity and respect.

Observations throughout the inspection evidenced that staff were compassionate when responding to distress.

Staff were observed as approachable and available for patients at all times during the inspection.

Staff spoke positively and were respectful when asked about the needs of patients. Staff informed the inspector about each patient's personality, and focused on each patient's strengths rather their behaviours and risks.

Patients were offered the opportunity to attend their multi-disciplinary team meetings.

Patient forum meetings were held every two months. Minutes from the meeting were available and included an action plan.

Patients were provided with information to help them make choices about their care and treatment. This information was available in a format that met the communication needs of patients in Cranfield Ward 2 during the inspection.

All patients interviewed stated their right to refuse care and treatment was respected.

All observations of staff practice and interactions between staff and patients were positive. Staff were supportive and caring. Staff were observed to take time to reassure patients when distressed.

Patients and relatives were satisfied with the care provided on the ward.

There was information displayed in a format that met the communication needs of patients in relation to patient experience feedback, compliments the number of hours of activities for the month, and number of safeguarding vulnerable adults. This information was updated every month.

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

There was a mechanism in place to develop the competence and confidence of junior nursing staff. For example junior nursing staff get the opportunity to take charge of the ward when senior nursing staff are on duty and all nursing staff get the opportunity to lead the weekly reflective practice sessions.

The senior nurse manager demonstrated their dedication in developing nursing leadership by encouraging staff to develop service improvement initiatives. Nursing staff and patients complimented the senior nurse manager and stated they were available when required and were regularly present on the ward.

The inspector observed effective nurse leadership during the inspection. On day one and day two of the inspection the ward manager and deputy ward manager were not on duty. A senior band 5 nurse was on duty both days. The inspector observed the delegation of duties, the management of an incident and the support of the inspection. Nursing staff were observed to be organised, calm and ensured there was minimum disruption to patients and the ward routine. This was commended during feedback.

Senior band 5 nursing staff were observed complimenting junior nursing staff following the management of the incident as recorded above.

All staff interviewed were aware of their responsibilities in relation to safeguarding vulnerable adults and the management of incidents.

There was a senior management on call rota available for staff.

Staffing levels met the needs of the patients. There were on average 8 – 10 staff on day duty and 4 staff on at night. Bank staff shifts were completed mainly by staff working on the ward. Agency staff had not been used on the ward.

Staff stated they felt well supported and had received up to date supervision and appraisals. Although health care assistants did not receive formal supervision, they were supported through staff meetings and the weekly reflective practice sessions.

The ward manager completed an audit of the care documentation every month.

There was governance oversight in relation to average length of stay and occupancy levels.

The ward manager completed and submits a quality monitoring report every month to the senior nurse manager. The ward manager and senior nurse manager agree an action plan from the report.

The senior nurse manager completed a quality report following unannounced visits to the ward.

A Learning Disability Services Governance meeting is convened every two months.

A Learning Disability Service Dashboard is completed every three months.

Learning from incidents was disseminated to staff through a number of mechanisms. There was a learning board and learning is also disseminated via reflective practice.

Staff received the outcomes from incidents they had reported and recorded on the incident recording system (DATIX).

Patient experience is gathered, via patient forum meetings, patient satisfaction surveys, and by advocacy services. Outcomes from the patient satisfaction surveys were displayed on the ward every month.

Staff stated the multi-disciplinary team worked well together.

Staff stated they were supported by MDT and found all of the team approachable and that they were listened to.

There was a clear organisational and management structure in place. Staff interviewed were aware of the lines of accountability.

The ward receives clerical support one day per week.

Staff had received up to date mandatory training.

There were governance arrangements in place in relation to the management of patient finances.

Areas for Improvement

Involvement in discharge planning

14 out of 16 patients on the ward were assessed as ready for discharge. A number of patients on the ward were admitted due to a breakdown in their community placements. Patients expressed their frustration as their lives were more restricted than necessary. Of note patients who required admission for care and treatment had to wait for a bed to become available. Inspectors were informed that there was a lack of involvement of consultant psychiatrists and ward nursing staff in the commissioning, planning and delivery of community placements. This applies to the hospital site. There were a lack of meetings between consultants and senior managers.

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 13 January 2017.

Provider Compliance Plan Cranfield Ward 2	
Priority 1	
The responsible person must ensure the following findings are addressed:	
Area for Improvement No. 1 **Ref:** Quality Standard 5.3.1(a) **Stated:** First time **To be completed by:** 2 December 2016	<u>Speech and Language Therapy</u> One patient who had a history of choking had a nursing care plan in place which included guidance from speech and language therapy (SALT). However the patient had not been reviewed by SALT since August 2015. This was addressed with the deputy ward manager during the inspection and an appointment was arranged for SALT to review the patient on Friday 2 December 2016.
	Response by responsible person detailing the actions taken: In response to this area of improvement SALT have seen the patient on 2nd December as arranged.
Priority 2	
Area for Improvement No. 2 **Ref:** Quality Standard 5.3.1(a) **Stated:** First time **To be completed by:** 28 February 2017	<u>Patient risk assessments and management plans.</u> Each comprehensive risk assessment and management plan was reviewed in accordance with PQC guidance. The information recorded in the review documentation was comprehensive and relevant however the review did not always reflect if the risk had reduced remained the same or increased.
	Response by responsible person detailing the actions taken: In response to this area of improvement, each review of the CRA and management plan now reflects if the risk has reduced, remained the same or increased.
Area for Improvement No. 3 **Ref:** Quality Standard 5.3.1 (a) **Stated:** First time	<u>Financial capacity assessments.</u> One patient did not have their financial capacity assessment completed in full. Although it was recorded that the patient was assessed as incapable with managing their finances the scores were not completed to confirm the rationale for this decision.

To be completed by: 28 February 2016	**Response by responsible person detailing the actions taken:** In response to this area of improvement, the ward manager has ensured the financial capacity assessment scores are completed and confirm the rationale for the decision.
Area for Improvement No. 4 **Ref**: Quality Standard 6.3.1 **Stated**: First time To be completed by: 28 February 2016	<u>Involvement in discharge planning</u> 14 out of 16 patients on the ward were assessed as ready for discharge. A number of patients on the ward were admitted due to a breakdown in their community placements. Patients expressed their frustration as their lives were more restricted than necessary. Of note patients who required admission for care and treatment had to wait for a bed to become available. Inspectors were informed that there was a lack of involvement of consultant psychiatrists and ward nursing staff in the commissioning, planning and delivery of community placements. This applies to the hospital site. There were a lack of meetings between consultants and senior managers.
	Response by responsible person detailing the actions taken: In response to this area of improvement – the Trust has a number of monthly meetings to plan for those delayed in their discharge from hospital with senior managers and the HSCB which includes senior managers from the other relevant Trusts. The Trust will review the membership of each group to ensure broader involvement of Consultant Psychiatrists and operational leads. The Trust will also review the communication strategy for each meeting to ensure all relevant staff are fully aware of and can contribute to the commissioning planning and delivery of community placements.
Priority 3	
Area for Improvement No. 5 **Ref:** Quality Standard 5.3.1(a) **Stated:** First time **To be completed by:** 31 May 2017	<u>Care plans</u> Goals were not consistently recorded in patient's care plans. It was noted that goals were documented as interventions and were not specific to the assessed need. For example it was documented that one patient's mood fluctuates and the goal was to promote positive mental health. This would have made the effectiveness of this care plan difficult to measure.
	Response by responsible person detailing the actions taken:

	In response to this area of improvement, recording of goals is currently being addressed through ongoing care plan training and will be audited through the care audit procedure.

Name of person(s) completing the provider compliance plan	Linda Macartney		
Signature of person(s) completing the provider compliance plan		**Date completed**	January 2017
Name of responsible person approving the provider compliance plan	Martin Dillon		
Signature of responsible person approving the provider compliance plan		**Date approved**	January 2017
Name of RQIA inspector assessing response	Wendy McGregor		
Signature of RQIA inspector assessing response	Wendy McGregor	**Date approved**	17 January 2017

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