The Regulation and Quality Improvement Authority

RQIA

Mental Health and Learning Disability

Unannounced Inspection

Ross Thompson Unit, Causeway Hospital

Northern Health and Social Care Trust

15 & 16 December 2014

npm national preventive mechanism

informing and improving health and social care
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Contents

1.0 General Information

Ward Name	Ross Thompson Unit
Trust	Northern Health & Social Care Trust
Hospital Address	Causeway Hospital 4 New Bridge Road Coleraine BT52 1HS
Ward Telephone number	028 70327032
Ward Manager	Geraldine McQuillan
Email address	geraldine.mcquillan@northerntrust.hscni.net
Person in charge on days of inspection	15 December 2014 Morning: Elaine Adair (Staff Nurse) Afternoon: Valarie Wisener (Staff Nurse) 16 December 2014 Stephen Emo-Haines (Deputy Ward Manager)
Category of Care	Acute Mental Health Inpatient
Date of last inspection and inspection type	17 June 2014, Patient Experience Interviews
Name of inspector(s)	Wendy McGregor Kieran McCormick Nichola Rooney

2.0 Ward profile

Ross Thompson Unit is a 21 bedded admission ward set within Causeway Hospital. The purpose of the ward is to provide assessment and treatment to male and female patients who require care and treatment in an acute psychiatric environment. The ward has 18 allocated beds for patients aged 18 – 64 years and four beds allocated to patients aged over 65 years. Patient sleeping accommodation is provided in two and four bedded dormitories and single bedrooms.

On the days of the unannounced inspection there were four patients detained in accordance with the Mental Health (Northern Ireland) Order 1986.

Inspectors noted the ward was welcoming. The ward was well lit, well maintained, clean and fresh smelling. There were separate day spaces and dining areas for patients.

Patients in Ross Thompson ward received input from a multidisciplinary team which incorporated psychiatry, nursing, occupational therapy, physiotherapy and social work. A patient advocacy service was also available.

3.0 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)**.**

3.1 Purpose and Aim of the Inspection

The purpose of the inspection was to ensure that the service was compliant with relevant legislation, minimum standards and good practice indicators and to consider whether the service provided was in accordance with the patients' assessed needs and preferences. This was achieved through a process of analysis and evaluation of available evidence.

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

- 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.

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

3.2 Methodology

RQIA has developed an approach which uses self-assessment, a critical tool for learning, as a method for preliminary assessment of achievement of the inspection standards.

Prior to the inspection RQIA forwarded the associated inspection documentation to the Trust, 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 has three key parts; self-assessment, pre-inspection analysis and the visit undertaken by the inspectors.
Specific methods/processes used in this inspection include the following:

- analysis of pre-inspection information;
- 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 inspectors in preparing for this inspection.

The recommendations made during previous inspections were also assessed during this inspection to determine the Trust's progress towards compliance. A summary of these findings are included in section 4.0, and full details of these findings are included in Appendix 1.

An overall summary of the ward's performance against the human rights theme of Autonomy is in Section 5.0 and full details of the inspection findings are included in Appendix 2.

The inspectors would like to thank the patients, staff and relatives for their cooperation throughout the inspection process.

4.0 Review of action plans/progress

An unannounced inspection of the Ross Thompson Unit was undertaken on 15 and 16 December 2014.

4.1 Review of action plans/progress to address outcomes from the previous unannounced inspection

The recommendations made following the last unannounced inspection on 30 September 2013 were evaluated. The inspectors were pleased to note that all recommendations had been fully met.

4.2 Review of action plans/progress to address outcomes from the patient experience interview inspection

The recommendations made following the patient experience interview inspection on 17 June 2014 were evaluated. The inspectors were pleased to note that two recommendations had been fully met and compliance had been achieved in the following areas:

- patients records reviewed evidenced completion of a joint nursing and medical admission had been completed with the patient. Patients that spoke to inspectors expressed no concerns in relation to having to repeat information.
- there were no mal-odours identified in any area of the ward.

However, despite assurances from the Trust, one recommendation had not been fully implemented and will require to be restated for a second time in the Quality Improvement Plan (QIP) accompanying this report.

4.3 Review of action plans/progress to address outcomes from the previous finance inspection

The recommendations made following the finance inspection on 8 February 2014 were evaluated. However, despite assurances from the Trust, two recommendations had not been fully implemented. Both recommendations will require to be restated for a second time in the Quality Improvement Plan (QIP) accompanying this report.

4.4 Review of implementation of any recommendations made following the investigation of a Serious Adverse Incident

A serious adverse incident had occurred on this ward on 14 September 2014. Relevant recommendations made by the review team who investigated the incident were evaluated during this inspection. It was noted that compliance had not been achieved in relation to all recommendations made. Inspectors recognised that a number of the recommendations were specific to an individual patient. Inspectors however identified that the learning from this incident may reduce the likelihood of a similar incident reoccurring. As a

result inspectors have made associated recommendations within the Quality Improvement Plan (QIP) associated to this inspection.

Details of the above findings are included in Appendix 1.

5.0 Inspection Summary

Since the last inspection the ward has addressed a number of previous recommendations and implemented a number of positive changes. Inspectors noted improvement with enhancing patient involvement in their care and treatment and reducing the need for patients to repeat their information. There has been further development with increasing the availability of recreational and therapeutic activities, particularly at weekends.

The following is a summary of the inspection findings in relation to the Human Rights indicator of Autonomy and represents the position on the ward on the days of the inspection.

On the days of the inspection, information in relation to Capacity, Consent and Human Rights was available for staff and patients on the ward. Patient and/or relative involvement in all aspects of care was evident in the care documentation reviewed. Staff confirmed their knowledge of Capacity to Consent and informed the inspectors of the steps they took to ensure patients consented to care and treatment. Staff informed inspectors of how they would know if a patient was not consenting and the steps they would then take to ensure understanding. These included revisiting after a period of time or have another member of staff speak with the patient. Inspectors noted there was no reference to patient's capacity to consent for care, treatment or invasive procedures. Care plans did not provide guidance to staff on how to obtain or assess consent on an individual basis or the actions to take if consent was not obtained. However, the daily progress notes made reference that patients were involved and/or either agreed or disagreed to care and treatment on a daily basis.

Inspectors reviewed four patients care records. Care plans for all patients had been created using a generic template, none of the patient care plans were individualised and person centred. Care plans had been signed by the patient or where they had not been signed an explanation had been recorded. Where a patient had not signed, due to their presenting mental health, there was no evidence that the care plan had been revisited at another time. It was positive to note that patients subject to detention had a detention care plan in place that provided an explanation of the individuals rights whilst detained, this had been signed by the patient. Each patients care documentation included a family centred care plan, 'Think Child, Think Parent, Think Family'. The care plan was used as a tool to promote family involvement and maintain family connection throughout admission. Care plans indicated that they should be reviewed weekly; there was no evidence that the weekly review in each case was being completed. Due to the generic nature of care plans there was no recorded reference made to the consideration of patient's human rights and capacity to consent.

The Ross Thompson Unit hold daily Zoning meetings, patients are categorised into three areas red, amber and green. Zoning meetings allow the multi-disciplinary team (MDT) to review daily the plan of care for patients who are categorised red or amber. New admissions are automatically categorised as red and are reviewed consecutively for 3 days post admission. Patients can move between zones dependent upon their mental health. It was positive to note in daily care records that patients are consulted with daily in relation to their care during 1-1 time with their named nurse. In addition to daily MDT review; all patients are seen a minimum of once weekly by the ward consultant.

Inspectors observed therapeutic engagement and activities between staff and patients, staff were discreet and responsive to patient's needs. Staff demonstrated their knowledge of patients' communication needs, were familiar with patients' likes, dislikes and choices. Staff that inspectors spoke to demonstrated an awareness of capacity, consent and Human Rights. The ward held daily briefing meetings. This allowed for the sharing of information to all staff following training or discussion regarding the introduction of change or new policies.

There was evidence that staff had knowledge of patients' Human Rights, particularly Articles 3, 5, 8 and 14. However, there was little evidence of human rights considered in patients care documentation. Zoning meetings are conducted daily, indicate by way of a tick box, that human rights are considered. However, there is no elaboration or description of the specific considerations regarding patient's human rights.

Comprehensive risk screening tools were completed in accordance with Promoting Quality Care, Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services May 2010.

Patients had individualised assessments and plans for therapeutic and recreational activity plans, completed by the ward Occupational Therapist (OT). Information was displayed in relation to activities offered on the ward. Patients also had their own daily schedules which they devise in conjunction with the OT department. OT assessments and reports were included in the patients' care documentation; OT recommendations were included in patients' care plans. Patient participation in activities was recorded in the daily progress notes and included detail of patients' reaction to particular activities. Inspectors noted a positive improvement in the availability of activities at the weekend. Patients that spoke with inspectors confirmed activities took place at the weekends. However, there was no structured programme displayed to advise patients or staff of the activities that would take place.

Information was available for patients in relation to: the patient's charter; complaints; independent advocacy services; keeping healthy; deprivation of liberty; capacity; and consent. A ward information pack was available for

patients and relatives. Staff were familiar with how to access and effectively utilise advocacy services.

Exit from the ward was unrestricted and patients could leave the ward through use of entering a code, the code is displayed above the keypad. Inspectors noted that the ward provided a least restrictive environment for all patients. Any restrictions were specific to individual patients and in this case a rationale was provided within each patient's integrated care pathway (ICP). Care plans demonstrated that the restrictions were the least restrictive option. Inspectors noted that a blanket restriction was in place regarding sharp items, including razors and scissors; these were removed from patients to help ensure the safety of everyone on the ward, in accordance with policy and procedure. The removal of these items was discussed in the patient information booklet and patients could access these items as required and upon request to staff. Care documentation reviewed by the inspectors did not demonstrate that the removal of items from patients had been discussed with each patient.

Staff who met with inspectors demonstrated their knowledge and understanding of the Trust's policy and procedure on the use of restrictive practices and were familiar with the Deprivation Of Liberty Safeguards – Interim Guidance DHSSPS 2010.

There were no patients on the ward whose discharge was delayed. Inspectors reviewed information in patients care records of the actions taken by staff to prepare a patient for discharge, this included trial leave and discussions with patients and family. Inspectors could evidence that imminent discharges were discussed at Zoning meetings. When a patient is nearing discharge the community team were invited to the ward for a pre-discharge meeting. Inspectors could not evidence in any patient care records reviewed a discharge care plan or formal discharge pathway.

During the inspection the inspectors noted the atmosphere within the ward to be relaxed and patients presented as being at ease and comfortable in their surroundings. Nursing staff were continually available and nurse/patient interactions observed by the inspectors were noted to be respectful and supportive. Patients who met with the inspectors reported that they were able to speak with nursing staff as required and that they met with their consultant on a weekly basis.

Details of the above findings are included in Appendix 2.

On this occasion Ross Thompson Unit has achieved an overall compliance level of **substantially compliant** in relation to the Human Rights inspection theme of "Autonomy".

6.0 Consultation processes

During the course of the inspection, the inspectors were able to meet with:

Patients	**1**
Ward Staff	**5**
Relatives	**0**
Other Ward Professionals	**2**
Advocates	**0**

Patients

Inspectors spoke to one patient. The patient that spoke with inspectors spoke positively regarding time spent on the ward and also spoke positively of the ward staff. The patient also confirmed that they had been provided an opportunity to read and sign their care plan. The patient informed inspectors about their daily activities. The patient discussed with inspectors a number of personal concerns, post discussion with the patient these were addressed with the deputy ward manager.

Relatives/Carers

There were no relatives available to meet with inspectors on the days of the unannounced inspection.

Ward Staff

Inspectors met with nursing staff on the ward. All staff stated they felt well supported and that the ward manager was approachable. Staff who spoke with inspectors had no concerns in relation to patient care; all staff stated that they felt patients on the Ross Thompson unit were well cared for. Staff expressed concerns in relation to the new hospital beds. Staff advised that patients were finding the beds uncomfortable, mattresses did not fit beds and that beds were too low and straining on the back. Staff also discussed with inspectors concerns regarding limited information received with new admissions, particularly out of hours. These concerns were addressed with the nursing services manager during feedback.

Other Ward Professionals

The inspectors met with two visiting ward professionals over the course of the two days. All professionals that met with inspectors were able to provide an explanation as to their role and function within the ward. Professionals were

also able to provide a summary of their perception of how the ward was performing. All professionals spoke highly of the care delivered on the ward. The ward based Occupational Therapist (OT) provided a detailed overview of the recreational and therapeutic activities that take place on the ward. Their involvement in assessment and planning and the role they took in the discharge planning process. The OT spoke positively regarding the care and treatment delivered to patients on the ward.

The Consultant Psychiatrist met with inspectors and spoke positively regarding the care and treatment provided to patients on the ward. The consultant expressed concerns regarding a possible reduction in staffing as a result of the planned reduction in bed numbers.

Advocates

There were no advocates available to meet with inspectors on the days of the unannounced inspection.

Questionnaires were issued to staff, relatives/carers and other ward professionals in advance of the inspection. The responses from the questionnaires were used to inform the inspection process, and are included in inspection findings.

Questionnaires issued to	Number issued	Number returned
Ward Staff	20	8
Other Ward Professionals	5	2
Relatives/carers	23	1

Ward Staff

Eight questionnaires were returned by ward staff

The inspectors noted that information contained within the staff questionnaires demonstrated that five staff were aware of the Deprivation of Liberty Safeguards (DOLS) – interim guidance. Two of the eight staff members had received restrictive practice training and were aware of restrictive practices on the ward. Examples of restrictive practices as reported by staff included “1:1 observations”, and “MAPA”. Five of the eight staff members indicated they had received training in the areas of Human Rights. Four of the eight staff had received capacity to consent training.

Three of the eight staff members, who returned their questionnaires prior to the inspection, stated they had received training on meeting the needs of patients who require support with communication. Staff indicated that patient’s communication needs were recorded in their assessment and care plan. It was observed that staff responded appropriately and promptly to patient’s needs. All eight staff members reported that patients had access to

therapeutic and recreational activities and that these programmes meet the patient's needs.

Other Ward Professionals

Two questionnaires were returned by ward professionals in advance of the inspection. It was noted that information contained within the professional's questionnaires demonstrated that neither of the professionals were aware of the Deprivation of Liberty Safeguards (DOLS) – interim guidance. Neither of the professionals had received training in restrictive practices. Both professionals indicated they had not received training in the area of human rights however indicated that they had completed capacity to consent training.

The two ward professionals stated they had not received training on meeting the needs of patients who require support with communication. Both professionals indicated that patient's communication needs were recorded in their assessment and care plan. Professionals recorded that they were aware of alternative methods of communicating with patients. All professionals stated that these were used in the care setting and that the ward had processes in place to meet patients' individual communication needs. Ward professionals reported that patients had access to therapeutic and recreational activities and that these programmes meet the patient's needs.

Relatives/carers

One relative questionnaire was returned. Relative's comments included:

"Staff have been very helpful, taking the time to explain and listen to any concerns or advice required"

7.0 Additional matters examined/additional concerns noted

Complaints

The details of three complaints were sent to RQIA with the pre-inspection documentation. The inspectors reviewed the record of complaints held on the ward and in discussion with the deputy ward manager clarified the details. The deputy ward manager advised that all complaints had been fully investigated in accordance with policy and procedure and were now fully resolved.

Adult Protection Investigations

The inspectors met with the deputy ward manager and discussed the safeguarding activity on the ward. The deputy ward manager advised that staff were familiar with the Safeguarding Vulnerable Adult policy and procedure and were making appropriate referrals in accordance with policy and procedure.

Inspectors were provided with an overview of the 25 substantiated allegations. The deputy ward manager advised that there was one ongoing investigation regarding a patient currently on the ward. The deputy ward manager advised that the ward staff completed a vulnerable adult's referral for all patients who are commenced on close or special observations. The deputy ward manager advised that referrals for safeguarding investigation by ward staff were promptly completed and that protection plans are put in place.

Access to psychological therapies

A review of access to psychological therapies was undertaken as part of the inspection of this ward. In order to assess the access to psychological therapies, a range of information was reviewed.

The review is informed by professional and clinical guidance, provided by NICE, the Royal College of Psychiatry and British Psychological Society. As well as local guidance from DHSSPS Mental Health and Learning Disability Service Frameworks and the regional Strategy for Improving Access to Psychological Therapies.

There is a well-established evidence base for the effectiveness of psychological interventions as demonstrated in the expanding NICE guidance (eg Depression, CG90; Schizophrenia, CG82; Personality Disorder, CG78; GAD, CG113; PTSD, CG26; Alcohol-use disorders, CG115; Drug Misuse, CG51&52; Bi-Polar Disorder CG38). This guidance now underpins the range of treatments and interventions that should be available to patients attending mental health and learning disability services.

The Royal College of Psychiatry guidance, 'Do the right thing; how to judge a good ward' (2011), identifies ten standards for adult in-patient healthcare. Referring to access to psychological therapies, Standard 8 states:

"Psychological therapies are an integral part of the recovery process. Wards should provide access to the range of psychological interventions that National Institute for Health and Clinical Excellence (NICE) guidelines stipulate for the acute illness phase of psychosis and other diagnoses. All relevant guidelines recommend at least one psychological intervention per week for in-patients. Psychological therapies need to be provided by staff that have the appropriate skills and experience."

The RCPsych College Centre for Quality Improvement (CCQI) sets standards for the organisation and delivery of mental health services (AIMS). Their standards for in-patient services include guidance on access to therapeutic interventions, staffing, training and supervision. These include;

"Inpatients have access to specialist practitioners of psychological interventions more than one day per week per ward. At least one staff member linked to the ward is delivering one basic, low intensity psychological intervention. At least one staff member linked to the ward is delivering one

problem specific, high intensity psychological intervention. At least one staff member linked to the ward is delivering two or more problem - specific, high intensity psychological interventions (to correspond to two or more diagnostic criteria as per NICE guidance)."

CCQI guidance on training and supervision states that staff should receive training and supervision from specialist therapy practitioners. Wards should demonstrate that qualified staff from nursing, OT, psychiatry and clinical psychology receive ongoing training and supervision to provide a repertoire of problem - specific, low intensity and high intensity specialised psychological interventions, in line with NICE guidance.

With regard to local guidance the DHSSPS Mental Health Services Frameworks state that patients receiving inpatient treatment should have access to ongoing care in line with NICE guidelines, with a proposed outcome of a measurable increase in the percentage of people receiving psychological and social interventions.

Finally, the first recommendation of the DHSSPS 'Strategy for the Development of Psychological Therapy Services' states that;

"The provision of psychological therapies should be a core component of mental health and learning disability services. Services should be delivered by staff with the skills and competence appropriate to the level of interventions required, and to national and regionally agreed standards and guidelines".

The guidance also states that Trusts should re-design mental health and learning disability services around a stepped care model with access to psychological therapy services at all levels.

A review of access to psychological therapies was undertaken on the Ross Thompson Unit. In order to assess the access to psychological therapies, a range of information was reviewed. Information was gathered on the professional make-up of the multi-disciplinary team and access to specialist psychological therapists and clinical psychology within the trust. Information was also sought regarding the training and supervision of nursing staff and other mental health professionals in the delivery of low and high intensity psychological interventions. Written documentation was reviewed, including patient files, patient 'zoning' information, the ward therapy and activities timetable and patient self-help materials.

The multi-disciplinary team consisted of two Consultant Psychiatrists, one of whom was dedicated to older adults care and who was transferring to Holywell. The ward also included a Specialist Registrar and a Senior House Officer. There was a cohort of Occupational Therapists who were ward based, nursing staff and social work. Access to Speech and Language Therapy and Physiotherapy was available through referral within the Trust.

No internal referral to psychology is available for inpatients although clinical psychology services could be accessed on discharge, via the Trust Booking Centre. These referrals were subject to normal waiting times. It was acknowledged that many patients were too acutely ill to avail of meaningful high intensity psychological therapies. A proportion of patients remain on the ward for several months and could benefit from such therapeutic input. Specialist neuropsychological assessments, which would be of particular use in the diagnosis of personality or cognitive difficulties, were also reported as being unavailable. The consultant psychiatrist expressed concern regarding the lack of clinical psychology, stating that the ward would be unable to achieve AIMs standards, due to the lack of access to high intensity psychological interventions and specialist supervision of other professional staff. However the consultant confirmed that she had been liaising with the Head of Psychological Services and that funding has been agreed, although there was concern about the banding of the post and the fact that the post will cover three in patient wards. The consultant expressed concerns regarding the disconnect between in-patient and community services.

Therapeutic activities

A number of standards for provision of activities and therapies are provided within the CCQI AIMS guidance. These include the opportunity to be involved in negotiating an activity and therapy program, relevant to identified needs, that includes evening and weekend activity. This is recorded in patients care plan, and regularly monitored and reviewed.

All patients are offered specific psychosocial interventions appropriate to their presenting needs and in accordance with national standards, NICE (38.5 2).

Ward activities were provided by the Occupational Therapy Department. Three daily sessions of group activity were available Monday to Friday, as well as individual sessions, such as relaxation training. OT functional assessments were included in patient files. OT were also trained in carrying out individual and group WRAP sessions. Patients had limited access to activities at weekends and this was limited by availability of staff. Despite having a gym within the ward, the equipment could not be accessed by patients, due to the lack of trained staff to supervise.

Patient review

The senior ward nurse reported that there were currently 15 patients on the ward. He stated that there was usually a quick turnaround, although the longest stay patient had been there for over 8 months. Two patients were on 1:1 observations. He described the process of zoning and how this ensured that patients had appropriate review by the MDT.

The patient files demonstrated the input of OT during zoning meeting discussions. There was also evidence of patients attending individual and group OT sessions. There was no evidence of high intensity psychological

interventions in patient files although they would have been recommended as NICE treatments for the presenting problems. Furthermore, there was no access to neuropsychological or cognitive assessment for a patient with a query dementia presentation.

Training and supervision in psychological interventions

Trust mandatory training was available to staff working within the Ward. The senior nurse was trained in Cognitive Behavioral Therapy, but was unable to implement skills due to role and lack of supervision. It was reported that nursing staff are to be trained in WRAP. It will be important to ensure supervision is included. There was little evidence of supervision for staff in low intensity psychological interventions or high intensity psychological therapies.

Summary

The evidence for and requirement to provide patients with access to the range of evidence-based low intensity and high intensity specialist psychological therapies is presented through NICE guidance and the range of professional guidance reported above. Due to the positive work completed by the OT department, patients on the ward had access to a wide range of low intensity psychological and functional interventions.

Concerns regarding the lack of access to psychological therapies have been raised by the consultant psychiatrist in the ward and were currently being addressed. However, some anxiety was expressed regarding the appropriateness of the seniority and availability of the proposed post.

8.0 RQIA Compliance Scale Guidance

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.

Appendix 1 – Follow up on Previous Recommendations

The details of follow up on previously made recommendations contained within this report are an electronic copy. If you require a hard copy of this information please contact the RQIA Mental Health and Learning Disability Team:

Appendix 2 – Inspection Findings

The Inspection Findings contained within this report is an electronic copy. If you require a hard copy of this information please contact the RQIA Mental Health and Learning Disability Team:

Contact Details
Telephone: 028 90517500
Email: Team.MentalHealth@rqia.org.uk

Appendix 1

Follow-up on recommendations made following the unannounced inspection on 30 September 2013

No.	Reference.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	Ref: 2 5.5	It is recommended that staff are facilitated to attend complaints training **(2)**	Training records reviewed evidence that 32 of the 38 staff working on the ward had attended complaints training. The nursing services manager advised inspectors that further training will be scheduled for any remaining staff.	Fully met
2	Ref: 2 4.14	It is recommended that trust policies are regularly discussed at staff meetings and staff encouraged to comment on implementation. Policies should be updated regularly. **(2)**	Review of daily staff briefing records evidenced that each day staff discuss trust policies and procedures. This included the Safe Guarding Vulnerable Adults policy and any other policy that may have changed or that has been newly implemented. Review of staff meeting minutes also evidenced discussion amongst staff in relation to trust policies.	Fully met

Appendix 1

Follow-up on recommendations made following the patient experience interview inspection on 17 June 2014

No.	Reference.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	6.3.2 (f)	It is recommended that the medical staff ensure that all information is shared with the medical team to minimise the need for patients to repeat information.	Review of a sample of patients records evidenced that a joint nursing and medical admission had been completed with the patient. Patients that spoke to inspectors expressed no concerns in relation to having to repeat information.	Fully met
2	6.3.2 (g)	It is recommended that the ward manager develops a structured recreational activity schedule for weekends which will consider the individual needs and views of the patients.	Inspectors spoke with a patient who confirmed that activities are taking place at the weekends. Inspectors however were informed that there was no formalised timetable or schedule in place for weekend activities. Patients advised that they may not know in advance which activities would be taking place come the weekend.	Not met
3	5.3.1(f)	It is recommended the ward manager ensures that the odour in the bathroom in the female four bedded sleeping area is addressed.	Inspectors completed a tour of the ward, there were no mal-odours identified in the area of concern or in any area of the ward.	Fully met

Appendix 1

Follow-up on recommendations made at the finance inspection on 8 February 2014

No.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	It is recommended that the ward manager ensures that all items brought into the ward on admission that are removed by relatives are recorded. Record of receipt by the relative should be obtained.	Inspectors spoke with ward staff who advised that they do not document or record the removal of patient's items by relatives.	Not met
2	It is recommended that the ward manager ensures that records of purchases made and change returned to patients are maintained along with appropriate receipting processes.	Staff on the Ross Thompson unit do not hold monies belonging to patients. Staff however informed inspectors that they may on occasions, at a patient's request, purchase items from the shop. Currently staff do not retain financial transaction records for when patients give money to staff, the reasons for this, item purchased and monies returned.	Not met

Follow up on the implementation of any recommendations made following the investigation of a Serious Adverse Incident

No.	SAI No	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	NT-SAI-14-169	This patient needs flagged on Epex	Staff that spoke to inspectors advised that they do not have access to the Epex system. This was highlighted to the nursing services manager.	Not met
2	NT-SAI-14-169	If detained his admission requires to be risk assessed regarding use of illicit drugs, level of paranoia, risk	This recommendation is in specific relation to an individual patient. Records for this	Not assessed

		to self and others and consider most appropriate area to admit him to i.e. Holywell / Ross Thompson Unit.	patient were not available during the course of the inspection.	

Quality Improvement Plan

Unannounced Inspection

Ross Thompson Unit, Causeway Hospital

15 & 16 December 2014

The areas where the service needs to improve, as identified during this inspection visit, are detailed in the inspection report and Quality Improvement Plan.

The specific actions set out in the Quality Improvement Plan were discussed with the deputy charge nurse and other hospital personnel on the day of the inspection visit.

It is the responsibility of the Trust to ensure that all requirements and recommendations contained within the Quality Improvement Plan are addressed within the specified timescales.

Recommendations are made in accordance with The Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS, 2006.

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
1	6.3.2 (g)	It is recommended that the ward manager develops a structured recreational activity schedule for weekends which will consider the individual needs and views of the patients.	2	27 February 2015	A structured recreational activity schedule has commenced for the weekends. A notice board displayes the planned activities in advance and welcomes all patients. Views and choices of weekend activities are discussed and decided with patients at their two weekly patient meetings. A file is kept to record choices and attendance at the activities. The Occupational Therapist provides access to equipment as required for activities. The TI is planning for some Friday evening or Saturday morning sessions as an addition to existing schedule. A new recreational activity room has been developed by patients and staff.
2	5.3.1 (c)	It is recommended that the ward manager ensures that all items brought into the ward on	2	Immediate and	A new form has been developed to receipt any personal items removed by relatives. This will be

Recommendations are made in accordance with The Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS, 2006.

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
		admission that are removed by relatives are recorded. Record of receipt by the relative should be obtained.		ongoing	completed and copy kept in patients records. New signage has been erected on the ward to make relatives aware of the need to inform staff when removing items (with consent from the patient). On admission patients to be made aware of the need for staff to be informed if any items are given to relatives for safe keeping . this has been added to the new information leaflet. Staff have been informed about the new relatives receipt form via the daily briefing sessions.
3	5.3.1 (c)	It is recommended that the ward manager ensures that records of purchases made, and change returned to patients are maintained along with appropriate receipting processes.	2	Immediate and ongoing	New forms have been developed to record the purchases made and the exact change given to patients with receipts. These are held within the patients ICP notes. Staff have been informed about the new form and receipting processes via the daily briefing sessions.

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No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
4	8.3 (f)	It is recommended that the nursing services manager ensures that all ward based staff are provided with access to the Epex system.	1	Immediate and ongoing	The ward manager has identified all ward staff on an EPEX matrix and is prioritising the training, IT consolidation and provision of EPEX access for all appropriate ward based staff.
5	5.3.1 (a)	It is recommended that the ward manager ensures that all patients care plans are person centred and incorporate the holistic and individualised needs of the patient.	1	31 March 2015	All care plans have been reviewed by their named nurse in conjunction with their multi-disciplinary team and are holistic and person centred A Trainer is visiting the ward on 26th February 2015 to review progress, identify any training needs regarding care planning and to introduce an audit tool for the ward managers to use. This will help monitor standards and ensure training is embedded into practice.
6	5.3.1 (a)	It is recommended that the ward manager ensures all patients' care plans are reviewed in accordance with the time scale set. A record of this review should be included in the	1	Immediate and ongoing	Care plans are being reviewed by the named nurse in the timescales set and recorded in the individual pateints notes. A new form has been added to the ICP to make this process clearer. This process will be monitored by the ward

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		patient's notes.			manager within care planning audits and any deviation will be addressed with the named nurse for redress or action.
7	5.3.3 (b)	It is recommended that the ward manager ensures that all patients are provided with an ongoing opportunity to review their care plans as their mental state improves and that this is recorded and/or signed by the patient.	1	Immediate and ongoing	Following appraisal of this process, a new form was devised for use when jointly reviewing care plans with places for both patient and staff signatures, same to be held in patient's notes. This form was developed in liaison with Advocacy Services in RTU to ensure all patients are aware of their inclusion in care planning and care plan reviews. Managers ensure care planning is an integral part of the registered nurses operational supervision and will be discussed at individual sessions. Managers will communicate broader issues via the daily briefing sessions. Feedback regarding care planning is obtained from patients on an individual basis at review with their

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No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
					named nurse and also broader issues at patient meetings.
8	5.3.1 (a)	It is recommended that the ward manager ensures that patients care plans reflect consideration of the Human Rights Act, particularly for those patients that are subject to any form of restrictive practice.	1	31 March 2015	Care plans reflect consideration of The Human Rights Act 1998 in all aspects of care planning, especially with any forms of restrictive practice. Staff are undertaking training in this area and Leads for the ward within the senior nurses have been identified to support the team.
9	5.3.1 (a)	It is recommended that the ward manager ensures that a care plan is in place and regularly reviewed for any patient subject to any individual restriction, blanket restriction or deprivation of liberty. This should be discussed, agreed with the patient and documented accordingly.	1	31 March 2015	Deprivation of Liberty care plans are in place and are individualised to each patient. These are devised with the MDT and agreed and discussed with each patient when appropriate to that individual and documented. Staff will review care plans as detailed in relation to any form of restrictive practice with the patient and appropriate form to be signed by both staff and patient. All care plans especially those in relation to any restrictive practice or Deprivation of Liberty to

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No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
					reflect consideration of patient human rights and regularly review and audit by ward manager to take place and sisgned and placed in patient notes.
10	5.3.1 (a)	It is recommended that the ward manager ensures that all patients have a person centred discharge care plan that indicates the actions to support and prepare patients for discharge.	1	Immediate and ongoing	Discharge planning meetings are currently held in RTU with all disciplines for the ward and community setting represented in collaboration with patient and family. Discharge care planning to be discussed with the patient and endeavour to ensure same reflect the level of support to be provided to the patient on discharge. In order to ease transition from hospital to community setting, close liaison and involvement of all external agencies relating to patient care (post discharge) is promoted via discharge planning process. Same will be reflected in support planning documentation in discussion with patient and recorded accordingly.
11	6.3	It is recommended that the Trust ensures that access to the	1	31 May	The Head of Psychological Services is working

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		appropriate level of clinical psychology service, in terms of seniority and available sessions. Advice regarding this should be accessed via the Head of Psychological Services and/or professional body.		2015	with Trust Management to secure a robust service of inpatient psychological services and sessions at the level rquired.
12	6.3	It is recommended that the trust ensures that Clinical Psychology services are involved within the MDT, not only to provide specialist psychotherapy, but also to assist in the training and supervision of low and high intensity interventions.	1	31 May 2015	The Head of Psychological Services is working with Trust Management to secure a robust service of inpatient psychological services and to develop a skilled workforce in these areas.
13	6.3	It is recommended that the Trust ensures that training and supervision in the range of low intensity psychological interventions is made available to nursing and other appropriate mental health staff.	1	Immediate and ongoing	Staff have undertaken training in WRAP, motivational interviewing etc. and one nurse undertaking a CBT course. Staff are skilled in other low intensity interventions such as environmental management, relaxation, depression awareness, promoting health initiatives including walking, which are provided for patients daily.
15	7.3	It is recommended that the ward manager ensures that patients	1	31 March	The Gym is presently open two days per week

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		are facilitated to access the gym, in keeping with their care plan and to promote physical and psychological well-being.		2015	and this will increase to 5 days per week after 17th March 2015 (Staff are undertaking additional training). Patients have been made aware of the changes at the patient meeting and Advocacy Services. A posterinforming on the opening hours has been erected,.

NAME OF WARD MANAGER COMPLETING QIP	Mrs Geraldine McQuillan
NAME OF CHIEF EXECUTIVE / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Dr T Stevens

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Inspector assessment of returned QIP				Inspector	Date
		Yes	No		
A.	Quality Improvement Plan response assessed by inspector as acceptable	x		Kieran McCormick	19/02/15
B.	Further information requested from provider		x	Kieran McCormick	19/02/15