The Regulation and Quality Improvement Authority

RQIA

Mental Health and Learning Disability

Unannounced Inspection

Bronte Ward, Craigavon Area Hospital

Southern Health and Social Care Trust

5 and 6 November 2014

national preventive mechanism

informing and improving health and social care

www.rqia.org.uk

Contents

1.0 General Information

Ward Name	Bronte Ward, Craigavon Area Hospital
Trust	Southern Health and Social Care Trust
Hospital Address	68 Lurgan Road Portadown BT63 5QQ
Ward Telephone number	028 3833 4444
Ward Manager	Elaine McBroom
Email address	elaine.mcbroom@southerntrust.hscni.net
Person in charge on day of inspection	Elaine McBroom
Category of Care	Mental Health acute admissions ward
Date of last inspection and inspection type	10 June 2014 Patient experience interviews
Name of inspector(s)	Alan Guthrie

2.0 Ward profile

Bronte is an 18 bedded admission ward on the Bluestone hospital site. The ward provides care for patients with a mental illness who require assessment and treatment in an inpatient setting. The main entrance door to the ward is locked and access is controlled by ward staff or through use of a key fob.

The ward's multidisciplinary team consists of nursing staff and health care assistants, a consultant psychiatrist, a psychiatrist, an occupational therapist, a social worker and support staff. The ward is further supported by community teams including the crisis response and home treatment team, the management of personality disorder team and the management of eating disorder team.

On the day of the inspection the ward was full and nine patients were admitted in accordance to the Mental Health (Northern Ireland) Order 1986. One patient was under 18 years of age. The inspector noted that the care and treatment provided to the young person was appropriate and in accordance with Trust standards and best practice guidelines.

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 inspector. 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 inspector 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 inspector 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 Bronte Ward was undertaken on 5 and 6 November 2014.

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

The recommendations made following the last announced inspection on 29 and 30 March 2011 were evaluated. The inspector was pleased to note that all three recommendations had been fully met and compliance had been achieved in the following areas:

- The ward had developed procedural guidance regarding family visiting;
- Written information regarding patient rights and detention was provided in a range of languages;
- A programme of re-painting the ward had been completed and a further programme of repainting had been commenced.

4.2 Review of action plans/progress to address outcomes from the previous announced inspection.

The recommendations made following the last announced inspection on the 23 September 2013 were evaluated. The inspector was pleased to note that all six recommendations had been fully met and compliance had been achieved in the following areas:

- the trust had reviewed the locked door policy and procedure within the ward;
- procedural safeguards and robust care-plans regarding restrictions on patients had been implemented in accordance with DHSSPS Interim Guidance - 2010 (DOLS);
- the trust had reviewed the occupational therapy input to the ward;
- regular staff meetings were being held and documented;
- staff were encouraging patients to sign the minutes of the multidisciplinary meetings;
- the ward's courtyard area was kept clean and the outside areas continued to be maintained.

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

The recommendations made following the finance inspection on 6 January 2014 were evaluated. The inspector was pleased to note that all five recommendations had been fully met and compliance had been achieved in the following areas:

- patient property brought into the ward on admission was listed and receipted appropriately;
- a record of all staff who obtain the key to the safe where patient's money is stored was maintained, including the reason for access;
- there was a clear and transparent audit trail of patients' money received by the ward;
- a uniform policy for managing patients' finances within the Bluestone Unit was available and being implemented.

4.4 Review of action plans/progress to address outcomes from the patient experience interviews.

The recommendations made following the patient experience interviews on the 10 June 2014 were evaluated. The inspector was pleased to note that two recommendations had been fully met and compliance had been achieved in the following areas:

- the ward manager had completed a works request to ensure that the trust reviewed patient ensuite bathrooms and repaired or replaced defective flooring and facia;
- ward staffing levels were being reviewed with patients at the ward's patient/staff meeting.

4.5 Review of implementation of any recommendations made following the investigation of a Serious Adverse Incident (delete if not applicable)

A serious adverse incident had occurred in the Trust on 28 July 2013 Relevant recommendations made by the review team who investigated the incident were evaluated during this inspection. It was good to note that compliance had been achieved in relation to:

- the Trust's PARIS electronic information system had been implemented within the community services and would be made available to the Bronte ward in early 2015;
- access to patient information systems for staff who hold the bleep at Bluestone was available.

5.0 Inspection Summary

Since the last inspection the ward has addressed a number of previous recommendations and implemented a number of positive changes. These have included enhancing patient involvement in their care and treatment, providing information to patients in a number of languages, improving patient care plans, improving the patient staff meetings and redecorating the ward.

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.

Patient care documentation reviewed by the inspector provided evidence that each patient's progress, mental health status and capacity to consent was monitored and continually re-evaluated on a regular basis by the multi-disciplinary team. Care records evidenced that patients had been provided with information explaining their rights and patients were involved in decision making regarding their care and treatment. The inspector was able to evidence this through patient comments and feedback, within records of the multi-disciplinary team meetings and patient/staff meetings and through the availability of patient signatures on care records.

Information regarding patients' rights was available in the ward's reception area and within a mental health rights folder retained by the ward for patient use. It was positive to note that the ward provided information regarding the Mental Health (Northern Ireland) Order in a number of languages and patients were supported by an independent advocate who attended the ward on a weekly basis. The advocate informed the inspector that the advocacy service was promoted and respected by the ward staff team. Patients who met with the inspector reported no concerns regarding their ability to meet with the advocate and that they could discuss any issues they might have with staff as required. Patient contact with their relatives/carers was supported through the implementation of a flexible visiting timetable and appropriate visiting policies and procedures were also available. However, the visiting policy and child visiting policy were noted to be out of date. A recommendation regarding this has been made.

Weekly timetables for the ward's therapeutic and activity programmes were posted on the notice board in the patient's dining area and on the door of the occupational therapy room. Nursing staff who met with the inspector reported that nurse lead activities were timetabled each week and staff tried to ensure that activities were provided on a regular basis. Staff explained that although there were appropriate numbers of staff available for each shift activities were quite often cancelled due to nurses having to prioritise other care and treatment duties. The inspector was informed that the completion of 1 to 1 observations with patients and the admission and discharge of patients had resulted in prearranged activities having to be cancelled.

It was good to note that the ward's occupational therapist (OT) provided two group activities each day and completed 1:1 sessions with two patients each week. The OT also facilitated activities outside the ward in the Bluestone units shared activity area. The inspector was informed that patients could also access the unit's gym. Information received by the inspector through pre-inspection questionnaires and from patients and ward staff during the inspection evidenced that the unit's gym was not always available for patients on the Bronte ward. Insufficient numbers of nursing staff trained to facilitate gym sessions and staff concerns regarding patient physical health assessments were cited as reasons why patients could not access the gym. Recommendations regarding the Bluestone Unit gym have been made.

It was good to note that the ward was supported by the Trust's home treatment team and the management of personality disorder and eating disorder teams. The ward manager explained that staff from each team assisted ward staff in providing appropriate treatment plans for patients requiring specialist interventions. However, the inspector was informed, by the ward manager and the patient flow and bed manager, that patients did not have access to hospital based psychology services. The inspector was concerned that patients on the ward could not access psychology services until they had been discharged. A recommendation has been made.

Patients who met with the inspector stated that items including razors, phone chargers and sharp implements had been removed from them upon admission. Patients reported that they had agreed to these items being removed and they could access the items upon request to staff. The removal of items from patients was discussed in the patient information booklet and patients were also asked to sign a voluntary contract agreeing that staff could retain razors and sharp items (e.g. pen knifes) to help ensure the safety and well- being of all patients. Care documentation reviewed by the inspector demonstrated that the removal of items from patients had been discussed with each patient and this was reflected in patient care plans and in agreements signed by the patient.

During the inspection the inspector noted that the ward's main entrance door remained locked. Entry to the ward was controlled by an electronic access system. Patients who met with the inspector explained that they could leave the ward upon request providing this had been assessed as appropriate and was in accordance to the assessed risk and the patient's care plan. The inspector reviewed four sets of patient care documentation and noted that where the use of a restrictive practice with a patient was required, this had been discussed with the patient, agreed by the multi-disciplinary team and was reflected in the patient's risk assessment, care plan and continuous notes. Care documentation also evidenced that the use of a restrictive practice was continually monitored and regularly reviewed by the multi-disciplinary team. The inspector reviewed the ward's procedures regarding the use of observations and physical intervention and noted these to be appropriate and in accordance to Trust policy. The inspector noted that the system for reporting and recording use of a physical intervention required handwritten and electronic records. A recommendation has been made.

Discharge from the ward was discussed with patients and their relatives/carers upon the patient's admission. Discharge information was available in the patient information booklet and patient discharge plans reviewed by the inspector evidenced that the plan had been discussed with the patient and continually reviewed by the multi-disciplinary team. The inspector also noted that arrangements for the continuation of outpatient treatment, referral to the community mental health team and the provision of community services and social support had been actioned. This included a post discharge follow up appointment within seven days of the patient's discharge.

Details of the above findings are included in Appendix 2.

On this occasion Bronte 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 inspector was able to meet with:

Patients	6
Ward Staff	7
Relatives	0
Other Ward Professionals	0
Advocates	1

Patients

The inspector noted that patients on the ward presented as relaxed and at ease within their surroundings. Patients who met with inspectors were complimentary regarding the care and treatment they received from staff. Two patients expressed dis-satisfaction regarding the reasons why they were in hospital. Both patients informed the inspector that although they did not agree with their admission they had discussed this with medical and nursing staff and they understood their rights in accordance to the Mental Health (Northern Ireland) Order 1986. Patients' comments included:

"Ladies who do the meals are absolutely fantastic";

"Rules are O.K.";

"If I wasn't here I would be dead";

"They need more staff";

"There's a lack of things to do";

"Auxiliary's are very good";

"Some staff are brilliant";

"Staff are wonderful…very pleasant…only thing is there always busy";

"Some staff are more caring than others".

Relatives/Carers

No relatives/carers were available to meet with the inspector during the inspection.

Ward Staff

The inspector met with seven members of the ward's multi-disciplinary team (MDT). Nursing staff reported that they felt supported by their line management and they had no concerns regarding their ability to access mandatory training and supervision. The consultant psychiatrist reflected that the MDT was focussing on ensuring patients had appropriate crisis and discharge plans. The consultant reported that they felt the MDT was effective. Staff comments included:

"Really enjoy working here…there a good bunch";

"As a nurse I feel that my opinions are considered by the team";

"We are getting more patients with addiction problems";

"It's a really busy ward but I enjoy working here";

"Staffing levels are more settled…it was a hectic summer";

"Patient involvement in therapeutic and OT activities needs to be expanded and better resourced".

Other Ward Professionals

No other ward staff professionals were available to meet with the inspector during the inspection.

Advocates

The inspector met with the ward's advocate. The advocate informed the inspector that they found the ward staff to be supportive, respectful and responsive regarding the advocacy service. The advocate reflected that they felt ward staff considered the advocate's role as an integral aspect to patient care within the ward. The advocate commented that:

"I am always made to feel welcome and staff respond quickly to any requests made by patients".

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	11
Other Ward Professionals	5	3
Relatives/carers	16	2

Ward Staff

Nine nursing staff, a doctor and the occupational therapist returned questionnaires prior to the inspection. All nine members of ward staff reported awareness of the deprivation of liberty safeguards and they demonstrated knowledge and understanding of use of restrictive practices within the ward. All staff documented that they felt patients on the ward could access therapeutic and recreational activities and activities were designed to meet patient's individual needs. Six staff commented that the units gym facility was unavailable to patients due to a lack of appropriately trained staff. Ward staff comments included:

"Ward would benefit from the provision of an occupational therapy support worker to work specifically on rehabilitation with patients currently on the ward";

"Very limited occupational therapy service…lack of therapy/recreational therapy due to lack of resources and shortage of staff";

"Gym in unit but patients unable to access it as no ward staff trained in same";

"Staff (nursing) endeavour to carry out the planned weekly programme. This has its limitations due to high levels of patients requiring continuous observation";

Other Ward Professionals

Two community nursing staff and a forensic practitioner returned a questionnaire prior to the inspection. All three staff reported that they were not aware of the deprivation of liberty safeguards for patients. Staff documented that they understood the restrictive practices used on the ward and they reported that the ward provided appropriate information for patients. Staff comments included:

"Not enough staff which effects consistency";

"Understaffed at times and some patients who are ward based are unable to get to the gym";
"Limited staff trained in providing the gym facility".

Relatives/carers

Three questionnaires were returned by relatives prior to the inspection. Relatives commented that they felt that the treatment of patients on the ward was excellent and they had no concerns about their relative's ability to agree/consent to their care and treatments. Two of the relatives reported that they had been offered the opportunity to be involved in decisions in relation to the care and treatment of their relative. One relative recorded that they had been involved in discharge planning, one relative had been invited to a discharge planning meeting and one relative had not been involved in discharge planning. Comments recorded on the questionnaires included:

"I found the nursing staff and all involved in my relatives care and treatment excellent. They went beyond the extra mile and I would like to say thanks to all of the staff there";

"As my relative has been a patient on the Bronte ward I would just like to say that the care and service they get is very good. I would say that it has made them feel a whole lot better. Therefore I am very happy with the way my relative has been cared for by the doctors and the nurses and also the social worker";

One relative provided a number of comments:

1. "I feel relatives should be asked questions on admission to give a better picture of patients mental state prior to admission;
2. Meeting with both medical and nursing staff to explain treatment assessments/plans within a few days of admission;
3. Regular updates initiated by staff rather that the relative approaching staff for update or relying on patient who may not fully understand;
4. I feel the gym could have been made available…full use of the gym required".

7.0 Additional matters examined/additional concerns noted

The inspector noted that two patients who met with the inspector and two questionnaires returned prior to the inspection reported that staffing levels within the ward were not felt to be sufficient. The inspector discussed the staffing levels with the ward manager and examined the ward's staffing rota. The inspector noted no concerns regarding the levels of staff available on the days of the inspection and these were appropriate to meet the needs of patient's on the ward.

The Trust had completed a review of staffing within the Bluestone unit in November 2014. The decision to complete a review was in response to concerns expressed regarding staffing levels. The review concluded that staffing levels within the Bronte ward were appropriate and continued to be monitored daily by the ward manager and the patient flow and bed manager. The Trust had also commenced a nursing staffing exercise to ascertain the

required staffing levels specific to the continuously changing needs of each ward within the Bluestone unit. The results of this exercise will be shared with the Health and Social Care Board in the near future.

Complaints

The inspector reviewed complaints received by the ward between the 1 April 2013 and the 31 March 2014. Twenty complaints had been received including 13 from service users, two from relatives and five from other sources. 13 of the complaints related to concerns about staff attitude, three related to care practices and three complaints had been made as a result other concerns. All of the complaints were recorded as having been resolved to the full satisfaction of the complainant. The inspector found the ward's complaint procedure to be in accordance with the Trust's policy and procedure. The inspector noted that information relating to the complaints procedure was available to patients and their carer/relatives.

Ward Self-Assessment	
Statement 1: Capacity & Consent • **Patients' capacity to consent to care and treatment is monitored and re-evaluated regularly throughout admission to hospital.** • **Patients are allowed adequate time and resources to optimise their understanding of the implications of their care and treatment.** • **Where a patient has been assessed as not having the capacity to make a decision there are robust arrangements in place in relation to decision making processes that are managed in accordance with DHSSPS guidance.** • **Patients' Article 8 rights to respect for private and family life & Article 14 right to be free from discrimination have been considered**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
Patients' capacity to consent to care and treatment is reviewed as part of multidisciplinary team meeting and recorded on our weekly ward round sheets, which is explained to patients and their signature obtained if appropriate. Patients are allocated a Nurse from the team on a daily basis and are offered a one to one therapeutic session. Patients are reviewed by their Consultant at least weekly and are informed of the availability of additional individual one to one time with this Consultant. This is reinforced at our patient/staff meetings. Staff also spend time with their patients following multidisciplinary team ward round to inform them of outcomes/plan. Where a patient has been assessed as not having the capacity to make a decision staff ensure patients are aware of the independent advocacy service who can liaise with the multidisciplinary team and outside agencies on their behalf. Staff endeavour to involve the patient to the best of their understanding, or patient representative, in the decision making processes. The multidisciplinary team work collaboratively in an effort to augment functional abilities and review capacity on an individual basis. All patients on admission are provided with the information leaflet "Consent it's up to You".	4

Inspection Findings: FOR RQIA INSPECTORS USE Only	
Four sets of patients' care documentation reviewed by the inspector provided evidence that patient progress including ongoing assessment of patient's mental health status and capacity to consent was monitored and continually re-evaluated on a regular basis. Patient capacity to consent to care and treatment was continually reviewed and this was evidenced in reviews of each's patient's risk assessment and care plan. Patient progress was also reviewed weekly by the multi-disciplinary team. On admission patients had been asked to complete an admission agreement. The admission agreement detailed what a patient could expect from their time on the ward and that nursing staff were available to discuss any patient concerns or to clarify issues that a patient may not understand. The ward also provided patients with a "Consent it's up to you" leaflet. The leaflet explained that treatment requires a patient's consent and that a patient has the right to refuse treatment. The leaflet also reinforced the importance of ascertaining a patient's capacity to consent and ensuring communication support/aids are used as required. Each patient admitted to the ward was assessed by a Doctor and a member of nursing staff. The Doctor completed a mini mental state assessment (MMSE) which assessed the patient's perception, thought content and cognation. A nursing assessment and care plan were also completed with each patient. The inspector noted that nursing care plans included interventions to address patient mood and any perceptual/cognitive or thought disturbance. It was good to note that the ward's occupational therapist completed an assessment of each patient's needs within 24 hours of the patient's admission. The inspector reviewed the care documentation of one patient who had been assessed as not having the capacity to consent to their care and treatment. The patient's records evidenced ongoing assessment and continuous review by the multi-disciplinary team. The patient's care plan and continuous notes recorded that staff monitored the patient's capacity on a daily basis and the patient was informed of decisions regarding their care and treatment. Information for patients and their relative/carer regarding capacity and decision making was available. The patient booklet provided information regarding: who would be involved in providing care and treatment; the ward's advocacy services; discharge planning and patients' rights. Patients who met with the inspector reported that they understood why they were in hospital and that they could speak to nursing and medical staff as required. The inspector reviewed the ward's advocacy service records and noted that the advocacy visited the ward on a weekly basis. Five of the six patients who met with the inspector reported that they understood the role of the ward's advocacy service. The patient who reported they did not know what advocacy was relayed that	Substantially compliant

they believed staff had informed them about the advocacy service when they had been first admitted to the ward. The patient stated they would speak to staff about the ward's advocate. Information regarding patients article eight (private and family life) and article fourteen rights (free from discrimination) was available in the ward's reception area and within the ward's mental health rights folder. It was positive to note that the ward provided information regarding the Mental Health (Northern Ireland) Order in a number of languages including Polish and Portuguese. Patients who met with the inspector reported no difficulties in accessing contact with their family. The ward implemented a child visiting policy and procedures. The procedure included the provision of a room, away from the main ward, where visits from children could be facilitated. However, the ward's visiting policy and child visiting policy were noted to be out of date. A recommendation regarding this has been made.	

Ward Self-Assessment	
Statement 2: Individualised assessment and management of need and risk • **Patients and/or their representatives are involved in holistic needs assessment and in development of related individualised, person-centred care plans and risk management plans** • **Patients with communication needs have their communication needs assessed and there are appropriate arrangements in place to promote the patient's ability to meaningfully engage in the assessment of their needs, planning and agreeing care and treatment plans and in the review of their needs and services.** • **Assessment of need is a continuous process and plans are revised regularly with the involvement of the patient and/or their representative and in accordance with any changes to assessed needs.** • **Patients' Article 8 rights to respect for private and family life have been considered.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
All patients have a bio-psychosocial mental health assessment carried out prior to or on admission from which a multidisciplinary care plan is developed specific to individual needs which is signed by the patient and multidisciplinary team. All patients have individual care plans. A risk screening tool or comprehensive risk assessment is compiled involving all disciplines and family if appropriate, following which a management plan is agreed in keeping with Promoting Quality Care Guidance. Patients are given the opportunity to engage in daily 1:1 therapeutic sessions with a trained Mental Health Nurse. Nursing staff liaise with other disciplines e.g. SALT, brain injury team and utilise interpreting and sign language services as appropriate. Patients are also informed of the advocacy service who will meet with patients on a 1:1 basis and then liaise with the appropriate discipline on their behalf. Patients are also provided with the opportunity to have 1:1 time with their responsible Consultant Psychiatrist. Nursing and Social Work staff and the Patient Advocate are available to explain any written information for people with literacy difficulties e.g. Mental Health Order rights., Bluestone Unit information booklet, medication leaflets etc. Assessment of need continues on a daily basis with multidisciplinary involvement through daily patient	3

planning meetings and are weekly multidisciplinary team meetings with patient involvement. This is evidenced through patient and relative signature if appropriate on our weekly ward round sheets. Patients' notes are regularly reviewed through audit processes to ensure records are appropriately maintained. Visiting arrangements on the ward allow for flexibility and consideration of individual needs. There is a designated child/family room.	
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
Patient care documentation reviewed by the inspector included an admissions checklist, a patient admission agreement (detailing the ward's ethos and rules), a comprehensive medical and nursing assessment, a care plan and continuous patient progress notes. The inspector noted that patient care records were tidy and easy to follow. Information regarding each patient was comprehensive and up to date. Patient risk assessments were continually reviewed and care plans identified and addressed the patient's physical and psychological treatment and care needs. Patients' communication needs were addressed during the patient's initial assessment. The inspector reviewed the Trust's arrangements to support patients requiring communication assistance and noted that the Trust's interpreting service was available twenty four hours a day. Staff who met with the inspector demonstrated awareness and understanding of the different cultures within the local community and the importance of the Trust's interpreting service. The inspector noted that information regarding a patient's rights under the Mental Health (Northern Ireland) Order 1986 was available in English, Portuguese and Polish. Patient progress was monitored by nursing and medical staff on a daily basis and reviewed by the multidisciplinary team on a weekly basis. The multi-disciplinary team also completed daily patient planning meetings where patient progress and care needs were discussed and reviewed. Patients and staff who met with the inspector reported that communication and relationships within the ward were generally positive. Consideration of each patient's Article 8 right to respect for private and family life was evidenced through the information provided to patients upon their admission and through the ward's arrangements for patient's relatives. The patient information booklet discussed visiting times, provided contact information for the advocacy service and relayed what patients should expect from staff. Patients who met with the inspector reported no concerns regarding contact with their relatives. The inspector also noted that a list of patient named nurses was available on the notice board in the ward's dining area and patients were encouraged to access 1:1 time with nursing staff. The notice board also contained information for relatives including contact numbers for a family/carer support service.	Compliant

Ward Self-Assessment	
Statement 3: Therapeutic & recreational activity • **Patients have the opportunity to be involved in agreeing to and participating in therapeutic and recreational activity programmes relevant to their identified needs. This includes access to off the ward activities.** • **Patients' Article 8 rights to respect for private and family life have been considered.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
In Bronte Ward Nursing and Occupational Therapy staff plan a weekly programme of therapeutic and recreational activities, which involves individual and group work. Examples of groups provided through Occupational Therapy and relaxation, self-care, cooking, art. There is provision of materials at ward level for self-directed activities. Patient attendance in group work is recorded in the patients' notes and therapies file. Regular staff/patient meetings are held where patients can make suggestions and influence the types of activities available.	3
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
The ward's therapeutic programme included activities that were available in ward's activity room and the Bluestone shared activity room from Monday to Friday. The ward's activities timetable was available on the notice board in the patient's dining area and detailed that the ward's occupational therapist (OT) would be facilitating a relaxation session, an art class and cooking and self- care classes in the coming week. Activities provided by the nursing staff were also available. The ward's therapies book included a record of the activities that had been provided, the date and time the activity was completed and the names of the participants. The inspector reviewed the ward's nursing activity programme and records. Records evidenced that the activity sessions provided had been limited. Staff who met with the inspector reported that nurse lead activities were timetabled each week and staff tried to ensure that activities were provided on a regular basis. However, the inspector was informed that activities could not always be facilitated. Staff explained that although there were appropriate numbers of staff available for each shift, activities were quite often cancelled due to nurses having to prioritise other care and treatment duties including patient observations and the admission and discharge of patients. Staff who met with the inspector reflected on the importance of therapeutic activities for patients and the challenges of balancing the provision of activities against the priority of ensuring patients primary care needs were met. The inspector noted that the activities provided were designed to include all patients and not specific to	Substantially compliant

individual assessed needs. Patients who met with the inspector reflected that they enjoyed ward activities although two patients explained that they felt the number of activities available was limited. The ward's occupational therapist (OT) was available four days each week and provided two group activities each day. The OT also completed weekly 1:1 sessions with two patients who had been assessed as requiring a more focussed intervention. Activities available away from the ward included access to the facilities library and computer suite. The inspector was informed that patients could also access the facilities gym. However, six questionnaires returned to RQIA by ward staff and one questionnaire returned by a relative evidenced concern that the facility gym was not available to patients on the Bronte ward. The questionnaires recorded that there was insufficient numbers of staff trained to facilitate gym sessions. The ward manager informed the inspector that the ward had one member of staff who had completed the required training. The manager also explained that nursing staff had expressed concern that patients did not undergo a physical health assessment prior to commencing gym sessions. Recommendations regarding the facility gym have been made. The ward provided treatment and care to patients with varying levels of need. It was good to note that patients suffering from a personality disorder were receiving support from the Trust's personality disorder service. The service's team leader and the ward management team had agreed that the personality disorder service would provide ongoing support and advice to patients and staff on the Bronte ward. This included patients being able to access the service's mentallisation group and the provision of a reflective practice group for staff. The ward manager also reported that the ward received good support from the Trust's home treatment service and the Trust's eating disorder service. However, the inspector was informed that patients on the ward could not access the Trust's psychology services. A recommendation has been made. The inspector evidenced that patient's article eight rights to respect for private and family life had been considered with regard to the provision of therapeutic and recreational activities. This was evidenced through the provision of a range of individual and group activities which patients could choose to attend, the availability of OT and social work support and the involvement of the Trust's home treatment and eating disorder services. Visiting times with family or friends were protected and flexible and not negatively impacted on as a result of the therapeutic and activity programmes. Visits from patient's children/grandchildren could also be facilitated in a separate visiting room located outside the main ward area.	

Ward Self-Assessment

Statement 4: Information about rights • **Patients have been informed about their rights in a format suitable to their individual needs and access to the communication method of his/her choice. This includes the right to refuse care and treatment, information in relation to detention processes, information about the Mental Health Review Tribunal, referral to the Mental Health Review Tribunal, making a complaint, and access to independent advocacy services.** • **Patients' Article 5 rights to liberty and security of person, Article 8 rights to respect for private and family life and Article 14 right to be free from discrimination have been considered.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
Patients' rights are explained on admission or as soon as the patient mental state allows. This information is reinforced as appropriate during the admission. The Bluestone Unit Information Booklet, available to each patient, incorporates information in relation to patients' rights, expectations regarding care and treatment and responsibilities. The admission checklist prompts staff to ensure information is given regarding the independent Advocacy Service. The advocate is present on the ward each Tuesday and Thursday and approaches all newly admitted patients and those with specific requests. The advocate is also present at the patient/staff meeting on a fortnightly basis. Notices displayed on the ward provide the advocate contact number and patients are facilitated to make contact or staff will contact the advocate on request of patients. Patients are provided with appropriate information with what they can expect in their care and treatment and how to comment or complain. This is reinforced with provision of leaflets on the ward and notices on the ward notice boards. Approaching discharge nursing staff encourage patients to complete the Patient Experience Survey, which allows for suggestions or comments about their care and treatment The care plan for detained patients prompts nursing staff to ensure patients' rights are read and written leaflet given on each occasion of progression of the detention process or change in status and staff sign this accordingly. Support for patients wishing to make an application to the Mental Health Review Tribunal is provided by Medical, Nursing and Social Work staff.	4

Leaflets sourced and available in Polish and Portugeuse for patient and nearest relative regarding rights, complaints, process and advocacy, CAUSE and right to appeal to Mental Health Review Tribunal.	
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
The inspector noted evidence in the patient care documentation that patient's rights had been discussed with each patient upon their admission to the ward. Information regarding detention processes, the mental health review tribunal, making a complaint, and access to independent advocacy services was available on the ward's notice boards. The ward also retained a rights information file which patients and staff could access as required. Patients could also access a patient information folder which was available in each patient's bedroom. The folder detailed information in relation to patients' rights, what a patient should expect regarding their care and treatment, the responsibilities of the ward staff team, patient discharge and information regarding the advocacy service. The ward's advocate was available to meet with patients on Tuesdays and Thursdays and could be contacted as required Monday to Friday Nine to Five. The inspector met with the advocate. The advocate reported that they felt the ward's staff team were very supportive of the advocacy service and staff encouraged patients to speak with the advocate as required. The advocate also attended the patient/staff meeting which was held every two weeks. The inspector noted that the ward's main corridor displayed a poster which provided information regarding the human rights act. The notice board in the patient's dining room displayed a wide variety of information relevant to patients. The information available included a list of each patient's named nurse for the day, the patient activities schedule, the complaints procedure and information relating to voluntary, community and carer/relative support groups. Three questionnaires returned to RQIA by relatives/carers reflected that the ward staff promoted and encouraged family/carer involvement. Patients who met with the inspector explained that they knew why they were in hospital. Five patients reported that they understood what the advocacy service was and that they could meet with the advocate as required. One patient explained that they did not know what the advocacy service was although they were "pretty sure" staff had explained this to them previously. The patient stated that they would discuss the role of the advocate with a member of the ward staff. Information provided to patients admitted to the ward demonstrated that consideration had been given to patient's article 5 right to liberty and security of person, article 8 right to respect of private and family life and article 14 right to be free from discrimination. Consideration of patient's rights was also evidenced in patient care documentation, through the minutes of the patient/staff meetings, through the ward's independent	Compliant

complaints process and by the availability of an independent patient advocate.	

Ward Self-Assessment	
Statement 5: Restriction and Deprivation of Liberty • **Patients do not experience "blanket" restrictions or deprivation of liberty.** • **Any use of restrictive practice is individually assessed with a clearly recorded rationale for the use of and level of restriction.** • **Any restrictive practice is used as a last resort, proportionate to the level of assessed risk and is the least restrictive measure required to keep patients and/or others safe.** • **Any use of restrictive practice and the need for and appropriateness of the restriction is regularly reviewed.** • **Patients' Article 3 rights to be free from torture, inhuman or degrading treatment or punishment, Article 5 rights to liberty and security of person, Article 8 rights to respect for private & family life and Article 14 right to be free from discrimination have been considered.**	**COMPLIANCE LEVEL**
The multidisciplinary team in Bronte Ward care for all patients using the least restrictive means. Information is given to patients verbally and in written form, which is inclusive of explanation in relation to the ward door access control system and removal of specific items e.g. razors, phone chargers etc. There are times when patients require restrictive practice due to risk of harm to themselves or others or for protection of dignity. This is discussed in depth at multidisciplinary team level and individualised care plans are implemented. These care plans are reported on daily and reviewed regularly by the multidisciplinary team. We encourage patient involvement and seek their agreement, which is evidenced where possible by patient signature. Staff endeavour to protect patients' dignity and provide a safe environment where patients receive a high standard of care. The Trust has recently introduced training through the Clinical Education Centre on Deprivation of Liberty Safeguards. This is currently being rolled out to staff.	3
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
Patients who met with the inspector stated that items including razors, phone charges and sharp implements	Substantially compliant

had been removed from them upon admission. Patients reported that they had agreed to these items being removed and that they could access the items upon request and if it was assessed as being in accordance to their care and treatment needs. The removal of items from patients was discussed in the patient information booklet and patients were also asked to sign a voluntary contract agreeing that staff could retain certain items to ensure the safety and well- being of all patients. Care documentation reviewed by the inspector demonstrated that the removal of items from patients had been discussed with each patient and this was reflected in agreements signed by the patient.

The ward's main entrance door was locked and access was controlled by ward staff using a key fob and a access control system located in the ward's main office. Patients who met with the inspector confirmed that they could leave the ward upon request providing this had been assessed as appropriate and was in accordance to the assessed risk and the patient's care and treatment needs. Care documentation reviewed by the inspector recorded that the use of a restrictive practice with a patient had been discussed with the patient, agreed by the multi-disciplinary team and reflected in the patient's risk assessment, care plan and continuous notes. The inspector found evidence that the use of restrictive practices was continually monitored by nursing staff and reviewed daily by the multi-disciplinary team.

Staff who met with the inspector relayed appropriate understanding of the use and purpose of restrictive practices and the impact restrictions had on patients and their rights. Patient continuous notes reviewed by the inspector recorded that nursing and medical staff monitored the use of restrictions on a daily basis. On the day of the inspection two patients were receiving 1 to 1 observations. The inspector reviewed observations records and noted these to have been completed in accordance to Trust policy and procedure.

The inspector reviewed the ward's processes for recording and reporting the use of physical intervention. Records relating to the use of restraint were completed appropriately, attached to an incident report and forwarded to the Trust's governance and senior management teams using the datix computer information system. The inspector was informed that to complete a restraint form nursing staff had to scan the handwritten restraint form onto a computer, email the scanned copy to their Trust email account and then logon to the datix system before attaching the emailed scan copy to the incident report. The inspector was told that this process was necessary as incident reports were completed using an electronic proforma retained on the datix system and the restraint form had to accompany the related incident report. A recommendation has been made.

The inspector noted that patients' article three right to be free from torture, article five right to liberty and security of person, article eight right to a private and family life and article 14 right to be free from discrimination had been considered. This was evidenced through entries in patient care documentation and through the management and use of restrictive practices with individual patients. Patient care documentation reviewed by

the inspector demonstrated that the use of a restrictive practice had been individually assessed, was proportionate, monitored by the multi-disciplinary team and implemented and completed in accordance to Trust policy and procedure. The ward's complaints procedures, patient/ staff meeting and the availability of the ward's advocate on Tuesdays and Thursdays provided patients with additional safeguards and helped to ensure that each patient had appropriate opportunity to express their opinions and concerns. It was good to note that the ward's advocate felt that ward staff understood the role of the advocate and were supportive to patients and the advocate.	

Ward Self-Assessment	
Statement 6: Discharge planning • **Patients and/or their representatives are involved in discharge planning at the earliest opportunity.** • **Patients are discharged home with appropriate support or to an appropriate community setting within seven days of the patient being assessed as medically fit for discharge.** • **Delayed discharges are reported to the Health and Social Care Board.** • **Patients' Article 8 rights to respect for private and family life have been considered.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
Bronte Ward involves patients and their families/representatives in discharge planning from the earliest opportunity. This is further facilitated by involvement of a Home Treatment Team Practitioner who is now based in the Unit enabling a more efficient process of assessment of patient's suitability for transfer of care to the Home Treatment Team. Our Home Treatment Practitioner endeavours to attend ward daily planning meetings, weekly monthly disciplinary meetings and discharge planning meetings. Criteria for discharge and estimated date of discharge are discussed with the patient and their families and this is evidences on the ward round sheet and signed by the patient and multidisciplinary team members. Delayed discharged are monitored and audited by the Patient Flow and Bed Management Co-ordinator. These are reported as part of statutory returns. Nursing staff are trained in WRAP and Recovery Model approach to care.	3
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
Discharge planning was discussed with patients and their relatives/carers on their admission and this was evidenced in patient care documentation reviewed by the inspector and within patient discharge plans. The patient information booklet included sections describing the arrangements for patient discharge. Discharge planning for each patient was reviewed and discussed at the patient's weekly multi-disciplinary care review meeting. The patient's consultant, the ward manager/charge nurse, the patient's named nurse, the ward's social worker, the ward's occupational therapist and a member of the home treatment team attended the	Compliant

meeting. Discharge planning with patients was completed through one to one contact with the patient and their family/carer, continued review by the multi-disciplinary team (MDT) and via ongoing liaison with the community home treatment and mental health teams. Patients who met with the inspector reported no concerns in being able to involve their family/carer in their care and treatment. Discharge records reviewed by the inspector evidenced that arrangements for the continuation of outpatient treatment, provision of community services or social support were discussed. On the patient's discharge a referral to the patients local community mental health team (CMHT) had been completed and a follow up appointment, within seven days of the patient's discharge, was arranged. The patient's is then transferred to the CMHT worker identified as the patient's keyworker. The keyworker provides community based treatment and support to the patient. The inspector was informed by the ward manager and the patient flow and bed manager that the ward had no patients subject to a delayed discharge. The inspector noted that three patients had been on the ward for a long period of time. Each of the patients were noted to have complex care and treatment needs and all three had been assessed as requiring continued admission. The inspector noted that the patient's article 8 rights to respect for private and family life had been considered. This was evidenced through the patient's right to attend their weekly care plan review which included discussions regarding the patients discharge plan. Patients and staff who met with the inspector reflected that the involvement of relatives/carer in the care and treatment of the patient was promoted throughout the patient's admission. The ward operated flexible visiting hours and during the inspection the inspector noted relationships between staff, patients and visitors to be appropriate and respectful. The inspector was informed that none of the patients admitted to the ward during the inspection were experiencing a delayed discharge.	

Ward Manager's overall assessment of the ward's compliance level against the statements assessed	COMPLIANCE LEVEL
	3

Inspector's overall assessment of the ward's compliance level against the statements assessed	COMPLIANCE LEVEL
	Substantially compliant

Appendix 1

Recommendations restated from previous inspection completed on the 29 and 30 March 2011

No.	Reference.	Recommendations	Number of times stated	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	Ref: 2 (12.4)	It is recommended that the ward develops procedural guidance regarding family visiting the ward.	2	The visiting policy for the Bluestone Unit and the procedural guidance regarding the management of child visitors to acute adult mental health wards were being implemented by the Bronte ward. Staff who met with the inspector demonstrated an understanding of the ward's visiting procedures. Visits were facilitated away from the ward's bedroom areas and a room outside the ward was used to facilitate visits from children and young people. The inspector noted that the Bluestone Unit Visiting Policy and the Trust procedure on child visits to acute adult mental health wards required review. A new recommendation has been made.	Compliant
2	Ref: 17(6.3.2 C)	It is recommended that written information regarding patient rights and detention can be provided in a range of languages.	2	The inspector reviewed the written information available to patients subject to treatment in accordance to the Mental Health (Northern Ireland) Order (MH(NI)O 1986). Information leaflets detailing patient's rights and the process of admission under the MH(NI)O 1986 were available in a range of languages including English, Polish and Portuguese.	Compliant
3	Ref:17 (4.1)	It is recommended that a programme of re-painting the ward is commenced.	2	The inspector was informed that the ward's interior décor had been maintained since the completion of the inspection in March 2011. A further programme of repainting the ward had commenced in the latter part of 2014. The inspector noted that the ward's main corridor and lounge areas had been repainted. The repainting of	Complaint

				Patient's bedrooms was due to commence in January 2015.	

Follow-up on recommendations made following the announced inspection on 23 September 2014

No.	Reference.	Recommendations	Number of times stated	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	6 (24)	It is recommended that the trust review the locked door policy and procedure within this ward.	1	The ward's policy and procedure in relation to the main entrance access system had been reviewed by the Bluestone Unit senior management team. The patient flow and bed manager (PFBM) informed the inspector that the Bronte ward's main entrance controlled access system had been assessed by the senior management team as appropriate to meeting the care and treatment needs of patients admitted to the Bronte ward. The inspector reviewed the safeguards in place to ensure that voluntary patients did not experience a deprivation of their liberty. The ward manager and the PFBM informed the inspector that patient's not subject to admission in accordance to the MH(NI)O 1986 could leave the ward as required by using the doors buzzer. The buzzer alerted staff in the ward's main office and staff could then open the door immediately.	Compliant
2	6 (24)	It is recommended that the ward manager ensures procedural safeguards and robust care-plans regarding restrictions on patients be implemented to protect against actual or perceived deprivation of liberty in accordance with DHSSPS Interim Guidance - 2010 (DOLS).	1	The ward implemented a number of restrictions including controlled access to the ward and the removal of items such as razors, scissors and other sharp items. Patient care documentation reviewed by the inspector was noted to contain an admission agreement detailing the restrictions. Upon admission patients were asked to sign the agreement to verify their consent to the use of restrictions in relation to access to the ward and the removal of sharp items. The rational and use of further restrictive practices with	Compliant

				patients was reflected in patient care plans. The inspector reviewed two care plans of patients who were receiving 1:1 observations. The care plans were noted to have been completed appropriately and to contain a rationale for the use of observations. Each patient's continuous notes evidenced that ward staff reviewed the use of observations on a daily basis.	
3	2 (2.8 37.6)	It is recommended that the trust review Occupational Therapy input to ensure adequate support is available to the ward.	1	The patient flow and bed manager (PFBM) informed the inspector that occupational therapy (OT) input to the ward had been reviewed by the senior management team (SMT). The SMT had assessed that the OT provision was appropriate to meeting the care and treatment needs of patients admitted to the Bronte ward. The PFBM explained that the ward's OT resources remained under continuous review and any future resource requirements would be addressed by the SMT.	Compliant
4	2 4.14	It is recommended that the ward manager ensures regular staff meetings are held and documented	1	The inspector reviewed minutes of staff meetings that had been held from May 2014. Staff meetings were noted to have been held on a monthly basis. Records of the meetings were comprehensive and included ongoing review of ward staffing, safeguarding procedures, patient care plans and medication procedures.	Compliant
5	17 (6.3.2 D)	It is recommended that staff encourage patients to sign the minutes of the multidisciplinary meetings.	1	The inspector reviewed four sets of patient care documentation. Patient progress and care and treatment plans were reviewed by the multi-disciplinary team (MDT) on a weekly basis and the inspector noted patient signatures were available on the minutes of the MDT meetings. One record detailed that the patient had refused to sign despite encouragement from a member of nursing staff.	Compliant
6	17 (4.1)	It is recommended that the Trust ensures the courtyard	1	The inspector reviewed the ward's courtyard and noted that the stone surface areas had been power washed	Compliant

		is kept clean and outside areas are maintained.		and the hedges and shrubs were being maintained. The courtyard was generally clean although the area used by patients to smoke contained a large number of smoking debris. The ward manager informed the inspector that ward staff and patients took responsibility for cleaning the smoking debris and this was not completed consistently. A new recommendation reading the removal of smoking debris has been made.	

Follow-up on recommendations made at the finance inspection on 6 January 2014

No.	Recommendations	Number of times stated	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 are listed appropriately, the area of their storage or transfer recorded, and appropriate receipting undertaken, particularly when relatives remove items from the ward.	1	Upon a patient's admission to the Bronte ward nursing staff recorded and listed the patient's jewellery, phones and items assessed as being of value. Patient's clothing was not listed as patient's relatives completed laundry and replaced patient clothing on a regular basis. The inspector noted that records regarding patient property recorded if a patient retained their property and where the property was being stored. Valuable items retained by the ward were kept in the ward's safe. The inspector reviewed the safe records and noted that records had been completed appropriately. The safe contents were audited by the ward manager/charge nurse on a weekly basis.	Compliant
2	It is recommended that the ward manager ensures a record of all staff who obtain the key to the safe where patient's money is stored is maintained, including	1	The inspector was informed that patient monies were not held in the ward's safe. Patients were encouraged not to retain a large amount of money on their person during their admission. In circumstances where a	Compliant

	the reason for access.		patient has been assessed as lacking capacity their money is transferred to the hospital's cashier office. The cashier office then opens an account for the patient. The cashiers' office was noted to be accessible 24 hours a day 7 days a week through use of a drop safe which was located in the main general hospital located on the same site. The safe could only be opened by finance staff. The process of transferring a patient's money was overseen by two staff. The key to the ward safe was retained by the charge nurse and records of when the safe was accessed; who accessed it and why it had been accessed were available. The inspector noted that the safe record book had been completed appropriately and the safe contents were audited on a weekly basis by the ward manager/charge nurse.	
3	It is recommended that the ward manager ensures that there is a clear and transparent audit trail of patients' money received by the ward or patient.	1	Patient's money received by the ward was immediately transferred to the hospital's cashier office. The inspector reviewed the procedure for transfer and noted no concerns. Upon receipt of a patient's money the cashier's office opened an account in the patient's name. The audit trail was then monitored in accordance to the Trust's financial policy and procedures.	Compliant
4	It is recommended that the ward manager ensures that appropriate systems are put in place to record purchases made by staff on behalf of patients with related receipts. Appropriate, detailed and verified records of transactions must be maintained.	1	The inspector was informed by the ward manager that staff within the Bronte ward did not purchase items on behalf of patients. Patients wishing to purchase items could do so in the hospitals shop. This included patients subject to treatment in accordance with the Mental Health (Northern Irelands) Order 1986.	Compliant

5	It is recommended that the Trust develops and implements a uniform policy for managing patients' finances within the Bluestone Unit	1	A uniform policy for managing patients' finances within the Bluestone Unit was available and being implemented on the Bronte ward.	Compliant

Follow-up on recommendations made following the patient experience interview inspection on 10 June 2014

No.	Reference.	Recommendations		Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	Section 5, 5.3.1 (f)	It is recommended that the Trust reviews patient ensuite bathrooms and repairs or replaces defective flooring and facia.	1	The ward manager had completed a minor works request regarding patient ensuite bathrooms. The request had been forwarded to the Director of Mental Health services in July 2014 and was currently being reviewed.	Compliant
2	Section 5, 5.3.3 (a)	It is recommended that the ward manager reviews staffing levels with patients at the ward's patient/staff meeting.	1	The inspector reviewed the minutes of the weekly patient/staff 'have your say' meetings. Records detailed that meetings were held regularly and included discussions regarding staffing levels.	Compliant

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

Appendix 1

No.	SAI No	Recommendations	Number of times stated	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	21459	Mental Health Services should continue to progress the implementation of the new Community Information System which will improve issues regarding access to information about the services to patient has been or is known to; access to assessment information and general communication difficulties inherent in a paper based system.	1	The inspector reviewed the ward's position in relation to the Trust's community information system. The inspector was informed by the ward manager and the patient flow and bed manager that the PARIS information system would be implemented into the Bronte ward in 2015.	Compliant
2	21459	The Head of Acute Mental Health Services and Unscheduled Care Coordinator should review and/or arrange access to systems for staff who hold the bleep at Bluestone.	1	The ward manager and the patient flow and bed manager informed the inspector that staff providing out of hours support to the Bronte ward could access the Trust's electronic patient informations systems at any time. Staff were able to access the system within an office dedicated for their use out of hours.	Compliant

Quality Improvement Plan

Unannounced Inspection

Bronte Ward, Bluestone Unit

5 and 6 November 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 ward manager and the patient flow and bed manager 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	Section 5.3.1.(c and f)	It is recommended that the Trust reviews the visiting policy and the child visiting policy for the Bronte ward	1	28 February 2015	The Trust will review the visiting and child visiting policy for Bluestone Unit.
2	Section 5.3.3 (d)	It is recommended that the assistant director for mental health services ensures that there are sufficient numbers of staff on the Bronte ward trained to deliver gym sessions for patients.	1	31 March 2015	Bronte Ward continues to require significant additional nurse banking hours on a weekly basis to maintain safe and effective staffing levels which goes beyond the funded establishment for the ward. The demand created by the number of 1:1 observations and the complexity of patient need means that the nursing resource is frequently focused and absorbed in this safety measure as a priority. As a result staff on duty are not always free to support patient access to the gym. It is not possible to always ensure there are sufficient staff trained and on duty to deliver gym sessions. Staff have been identified for training which is not available until September 2015.
4	Section 7.3 (k)	It is recommended that all patients wishing to attend the gym complete the required medical assessment.	1	31 March 2015	The team is reviewing the timeliness of the medical assessments required to attend the gym.

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
5	Section 5.3.3.(d)	It is recommended that the Trust reviews the current provision of psychology support to patients within the Bronte ward and ensures that patients on the ward can access to the Trust's psychology service.	1	28 February 2015	The Psychology resource that is available to Mental Health Services in the Trust has been deployed in Primary Mental health Care and Support & Recovery Teams which are community based. The Trust has explored potential to divert the existing Psychology resource to the inpatient service but there is no capacity or additional funding to do so. The lack of psychology resources for inpatient services has been raised with commissioners but there is no immediate resolution to this service gap. The Trust will continue to raise this as a service pressure.
6	Section 8.3(c)	It is recommended that the Trust ensures that the 'use of physical restraint report template' is made available on the Trusts patient information system and that staff can complete this report electronically	1	31 March 2015	The acute wards in Bluestone are preparing to implement a new electronic care record based on the PARIS platform and functionality. This is a particularly challenging process for staff as they become familiar with new electronic recording mechanisms. Training and support for staff is and will continue to be provided. However the transition period will mean a period of time when both written and electronic records will be held. It

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
					is hoped that this period will be as short as possible before full implementation of electronic care records. The restrictive physical intervention details are being reviewed as to how this can be added to the Trust Datix system.

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

NAME OF WARD MANAGER COMPLETING QIP	Elaine McBroom
NAME OF CHIEF EXECUTIVE / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Miceal Crilly on behalf of Mairead McAlinden

Inspector assessment of returned QIP		**Yes**	**No**	**Inspector**	**Date**
A.	Quality Improvement Plan response assessed by inspector as acceptable	x		Alan Guthrie	5 January 2015
B.	Further information requested from provider				