The Regulation and Quality Improvement Authority

RQIA

Mental Health and Learning Disability

Announced Inspection

Cloughmore Ward

Craigavon Area Hospital

Southern Health and Social Care Trust

2 and 3 July 2014

national preventive mechanism

informing and improving health and social care

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1.0 General Information

Ward Name	Cloughmore Ward, Bluestone Unit
Trust	Southern Health and Social Care Trust
Hospital Address	Bluestone Unit Craigavon Area Hospital 68 Lurgan Road Portadown BT63 5QQ
Ward Telephone number	028 38366750
Ward Manager	Lynsey Erskine
Email address	Lynsey.erskine@southerntrust.hscni.net
Person in charge on day of inspection	Debra Proctor
Category of Care	Mental Health-Acute Admission
Date of last inspection and inspection type	January 2014 Financial inspection 7 April 2014 Unannounced inspection 10 June 2014 Patient experience
Name of inspector	Alan Guthrie Nicola Rooney

2.0 Ward profile

Cloughmore is an 18 bedded admission ward in the Bluestone Unit on the Craigavon Area Hospital site. The purpose of the ward is to provide assessment and treatment to patients with a mental illness. The main entrance doors to the ward are locked. Access to and from the ward can be gained via key fob.

The multidisciplinary team consists of a team of nursing staff and health care assistants, a consultant psychiatrist, doctor, social worker and an occupational therapist.

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 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 announced primary inspection of Cloughmore was undertaken on 2 and 3 July 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 10 and 11 May 2011 were evaluated. The inspector was pleased to note that eight out of thirteen recommendations had been fully met and compliance had been achieved in the following areas:

- Patient progress and treatment restrictions/implications were regularly reviewed by the multi-disciplinary team;
- patients meetings were held every two weeks and patients could access meeting minutes;
- the removal of personal electrical items had been individually assessed and was proportionate to the risk identified;
- the multi-disciplinary team (MDT) role and procedures had been reviewed and patients could attend the MDT meetings held each week;
- patients met with their consultant privately each week;
- no concerns were expressed by patients or staff regarding the ward's environment;
- patient risk assessments were reviewed regularly;
- ward staff continued to review the use of the facility gym and to promote opportunities for patients to attend;

However, despite assurances from the Trust one recommendation had not been fully implemented and four recommendations had not been 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 3 December 2013 were evaluated. The inspector was pleased to note that two of the recommendations had been fully met and compliance had been achieved in the following areas:

- Information relating to the availability of advocacy services was given to patients upon their admission. This was recorded on the patient's admission checklist;

- The inspector was informed by the senior nurse that the ward's smoking shelter had been reviewed and a patient satisfaction survey had been completed by ward staff. The shelter had been assessed as currently appropriate. The smoking arrangements within the ward were subject to further review in accordance with a DHSSPSNI directive regarding smoking within hospital sites.

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

The recommendations made following the finance inspection in January 2014 were evaluated. The inspector was pleased to note that one of the three recommendations had been fully met and compliance had been achieved in the following area:

- A record of all staff who obtained the key to the safe where patient's money is stored was being maintained.

However, two recommendations had not been fully implemented. Both recommendations had been partially met and will require to be restated for a second time in the Quality Improvement Plan (QIP) accompanying this report.

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

The recommendations made following the last unannounced inspection on 7 April 2014 were evaluated. The inspector was pleased to note that three of seven recommendations had been fully met and compliance had been achieved in the following areas:

- members of the multi-disciplinary team were recording actions in the patients' care documentation and use this information to update patient's comprehensive risk assessment and management plan;

- the views of patients and their family were incorporated in the patient's treatment and care planning;

- staff who met with the inspector had a clear understanding of their role and responsibilities in the event of a child protection concern. The ward's social worker and child protection nurse provided ongoing support, information and advice to staff in relation to any child protection concerns.

Compliance with three recommendations was not formally assessed during this inspection as the agreed timescales for implementation of the recommendations was 31July 2014.

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

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 identifying one consultant for the ward, patient involvement in the multi-disciplinary team meetings, and patients being able to meet with their consultant in private on a weekly basis.

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.

Inspectors reviewed patients' records and noted that patients were continually assessed, monitored and reviewed by ward staff and the multi-disciplinary team. This included ongoing assessment of each patient's mental health status and capacity to consent. Information for patients and their relative/carer regarding capacity and decision making was available. A patient information folder was accessible in each patient's room. The folder was appropriately presented and contained information regarding patient's rights. This included information explaining a patient's right to consent to treatment and the process followed when a patient cannot consent to care and treatment. In circumstances where a patient could consent staff used the "Best interests pathway capacity assessment tool" which was in keeping with DHSSPSNI guidance.

Patients were supported by members of the multidisciplinary team to understand their care and treatment through 1:1 and group sessions. The names of each patient's primary nurse were displayed daily on the noticeboard in the ward's dining area. Inspectors met with five patients all of whom reflected an understanding of why they were in hospital. Patients were invited to attend the multi-disciplinary ward round held every Thursday. Patients met with their consultant on a weekly basis and the consultant was also present in the ward every morning Monday to Friday. Patient notes reviewed by the inspectors, evidenced that patients were involved in decisions regarding their treatment and care.

Inspectors noted that patient files contained multi-disciplinary notes and updated information regarding patient progress. Each file contained a clinical assessment, risk assessment and care plan.

Patients who met with the inspectors stated that their contact with the nursing and medical staff was positive. Patients indicated that they could speak with nursing staff as required and they had weekly contact with their consultant psychiatrist. The notice board in the ward's dining room detailed each patient's named nurse. There was also information regarding the ward's social worker and the patient staff meeting.

There was 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 for patients on the ward. The patient information folder detailed information in relation to what a patient should expect regarding their care and treatment and the responsibilities of the ward staff team.

Information regarding the patient advocacy service and the availability of the advocate was posted in the patient's dining area. The advocate was available to meet with patients on Tuesdays and Thursdays and could be contacted as required. Inspectors were informed that the advocate also attended the patient/staff meeting which was held every two weeks.

The notice board in the patient's dining room displayed information regarding the human rights act. Specific information regarding patient's rights was also available. This included information on a patient's right to consent and make decisions about their treatment, and the right to involve their family/carer in their care and treatment. Questionnaires returned to the inspectors by relatives/carers reflected that the ward promoted family/carer involvement. The dining room notice board also displayed information and contact details regarding a local carer and relatives support group. There was also a poster detailing how patients could make a complaint.

Patients who met with the inspectors explained that they understood why they were in hospital and stated that they felt that staff were supportive and respectful.

Patients informed inspectors that they had not experienced blanket restrictions during their admission. Although personal items such as razors and phone chargers had been removed from patients upon their admission, the reasons for this had been explained and patients could access these items upon request. Patient care records detailed that the removal of personal items had been individually assessed and was proportionate to the risk identified.

Staff and patients who met with inspectors reflected that the ward promoted a least restrictive practice environment. The use of restrictive practices was individually assessed and recorded in patient care records. Patient continuous notes evidenced that nursing and medical staff monitored the use of restrictions on a daily basis. This included the use of observations and restraint interventions.

The multi-disciplinary team (MDT) met weekly and all professions working within the ward attended. Three members of staff who met with inspectors and two staff questionnaires received pre inspection (twelve returned) indicated that a number of ward staff felt that medical staff did not "listen" to their opinions. The inspector discussed these findings with the clinical acute services manager and the senior staff nurse. The inspector highlighted these concerns regarding the potential impact this could have on patient care and treatment, decision making within the multi-disciplinary team and ward staff morale. Both staff members expressed concern regarding these findings and stated that this would be discussed and reviewed by the senior management team and the ward staff team.

Details of the above findings are included in Appendix 2.

On this occasion the Cloughmore ward 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	six
Ward Staff	six
Relatives	none
Other Ward Professionals	Three
Advocates	none

Patients

Patients who met with inspectors were complementary regarding the care and treatment they received on the ward. Two patients highlighted their dissatisfaction at the lack of psychological therapies available. Patient comments included:

"I have been treated very well, very respectful";

"I wouldn't change anything";

"Ward's good, like a hotel";

"Staff's understanding";

"It's a lifesaver";

"I don't get any psychotherapy";

"There is no clinical psychologist on this ward".

Relatives/Carers

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

Ward Staff

Inspectors met with seven members of the ward's multi-disciplinary team during the inspection. 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. Three members of staff expressed concern regarding communication within the multi-disciplinary team. Staff also reported that patients could not access psychology services during their admission. Staff comments included:

"Notes are not always well organised";

"Nursing staff are not listened to by medical staff";

"There is a need for everyone to be involved in discharge planning particularly with those patients who are vulnerable".

Other Professionals

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

Advocates

Inspectors did not have the opportunity to meet with patient advocates on the days of the 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	**25**	11
Other Ward Professionals	**25**	1
Relatives/carers	**25**	5

Ward Staff

Twelve questionnaires were received from ward staff prior to the inspection. Ten questionnaires had been completed by nursing staff, one by medical staff and one by a member of the senior management team. All of the completed questionnaires evidenced that staff felt the ward had processes in place to meet patient's individual communication needs. Staff also reported that the ward provided appropriate information for patients regarding their rights. One member of staff expressed concerns at the lack of psychology input to the ward and two members of the nursing staff reported that medical staff did not listen to their opinions regarding patients. Staff comments included:

"Increasingly nursing staff feel that their opinion and input regarding patient care is not taken into account by the medical staff";

"No psychology input to the ward. Psychological therapy is limited";

Other Ward Professionals

No questionnaires were received from other ward professionals.

Relatives/carers

Five relatives/carers returned questionnaires prior to the inspection. All of the questionnaires reported that relatives felt that patient's had been offered the opportunity to be involved in decisions regarding their care and treatment. Relatives also relayed that patients undertook therapeutic and recreational activities on the ward. Two relatives indicated that they had been involved in the patients discharge plan and three had not. Relatives' comments included:

"Great care from the nurses";

"Very caring staff and a fine environment";

"Excellent care from the nurses, excellent help and advice for families";

"I feel that patients are not involved in enough activities during the day";

7.0 Additional matters examined/additional concerns noted

Complaints

Inspectors reviewed complaints received by the ward between the 1 April 2013 and the 31 March 2014. Four complaints had been received. One complaint related to staff attitude, one to care practice and two to issues associated with general issues not relating to the care and treatment provided by the ward. All of the complaints were recorded as having been resolved to the satisfaction of the complainant. Inspectors found the ward's complaint

procedure to be in accordance with the Trust's policy and procedure. Inspectors noted that information relating to the complaints procedure was available to patients and their carer/relatives.

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.

Information was sought on the professional of the multi-disciplinary team and on 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 working on the ward in the delivery of low and high intensity psychological interventions.

Written documentation was reviewed, including patient files, the Ward Therapy Timetable, the 'Therapies Diary", and the 'Model of In-Patient Care and Patient Flow in the Acute Care Pathway' (June 2012).

Staff working on the ward were interviewed, including Consultant Psychiatrist (providing holiday cover), nursing staff, senior social worker, and management for the service. Interviews were also conducted with two patients on the ward.

The multi-disciplinary team consists of a consultant psychiatrist, social worker, nursing staff and an occupational therapist. A nurse from the home treatment team also attends patient planning meetings.

Access to speech and language therapy and physiotherapy was available via referral within the Trust. It was reported that there is no access to clinical psychology or specialist psychological therapy services for patients on the ward.

No internal referral to psychology was available for patients although clinical psychology services could be accessed on discharge, via the Trust Booking Centre. These referrals were subject to normal waiting times. While it was acknowledged that many patients are too acutely ill to avail of meaningful high intensity psychological therapies, a significant 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.

Considerable dissatisfaction was expressed by each of the staff interviewed, as well as the in pre-visit questionnaire, about the lack of access to clinical psychology.

The consultant psychiatrist and doctor reported dissatisfaction around the lack of access to clinical psychology, using an example of the management of a

patient with treatment resistant schizophrenia. The consultant stated that while the psychologist to whom he referred the patient was agreeable to get involved in their management, psychology were unable to proceed as their manager reported that the service was not commissioned. The consultant described a 'massive disconnect' between in-patient and community services stating that it was unacceptable that there was no access to psychological assessment or treatment for inpatients.

Patient review

The senior staff nurse reported that there were currently 18 patients on the ward. She stated that the average length of stay on the ward was 15 days, although patients could be admitted from one day to a year.

On the day of the inspection the youngest patient was aged 26 years and the eldest, who was from another ward, was aged 75 years.

One patient was on 1:1 observations. Two patients had eating disorders and had been admitted for weight restoration.

One patient was well known to the ward as they had been admitted on a number of occasions for extended periods of time. The staff member reported some frustration at the lack of specialist psychological therapy available in the ward for this patient and referred to the medical notes highlighting the patient's ongoing lack of insight and querying the patient's capacity to consent to care and treatment, following an incident. While referral to a specialist service in an hospital in Northern Ireland had involved a neuropsychology assessment, this was not completed and there were a number of anomalies reported. Ongoing neuropsychological advice was not available while the patient was on the ward. The service could only be accessed when the patient was discharged, via a referral to the Community Brain Injury Team (CBIT). This was felt to be unsatisfactory.

The review of patient files confirmed the lack of access to specialist psychological therapy and neuropsychological assessment and interventions.

Other file reviews showed similar lack of access to psychological therapies.

Two patients were also interviewed with regard to their experience in the ward. Both were positive about their experiences and the commitment of the staff.

One patient reported that they had been in the unit for a number of weeks. They had been in other inpatient facilities previously, but found this ward to be more spacious and the environment more inviting. The patient reported a history of post-traumatic stress disorder (PTSD) and hearing voices. They also reported having attended a clinical psychologist fortnightly in the past. The patient reported they had received Eye Movement Desensitization Reprocessing (EMDR) and had been working on ways to manage auditory

hallucinations. The patient highlighted that there was no clinical psychologist on this ward and that they would prefer to have access to one rather than being treated with medication exclusively. The patient wished to return to work. Other improvements suggested by the patient included access to the gym, which had not been possible due to the lack of appropriately trained staff.

A second patient reported that they had been on the ward on this occasion for three months, having been a patient on this ward for some months previously. The patient stated that they were admitted for weight restoration. The management was largely provided by the community eating disorders (ED) nurse, who developed and advised on the treatment programme. The patient reported that they didn't get any psychotherapy, although they believed her ED nurse did some cognitive behavioural therapy (CBT) with them.

The patient reported that their time on the ward would have been enhanced by the opportunity to engage in Mindfulness training and Music Therapy, which they had accessed during their time in another inpatient facility in Northern Ireland. The patient also reported that supervised access to the gym would have been beneficial.

Training and supervision in psychological interventions.

Trust mandatory training was available to staff working on the ward. Some nursing staff had undertaken STORM training. It was reported that one-off training in WRAP was also planned to be undertaken. There was little evidence of supervision for low intensity psychological interventions or high intensity psychological therapies. Inspectors noted that a senior staff nurse had been trained in CBT at post-graduate level, while working in the community. While the nusre stated that this informed their approach, these skills were not specifically utilised, nor was there access to clinical supervision within the Trust. Some reticence about training nurses in CBT or other psychological therapies was voiced by the patient bed flow manager, who suggested that this would lead to nurses leaving to obtain higher graded posts.

Summary

The lack of access to psychological therapies highlighted by staff, patient care documentation reviewed and during interviews with patients is considered to be unacceptable.

Previous concerns raised by RQIA regarding the lack of access to psychological therapies have been met with the response that providing access to psychology in this ward would mean redirecting limited services from elsewhere in the Trust. This response is unacceptable and raises concerns about commissioning arrangements which require to be resolved. As with patients attending acute physical health services, those receiving treatment in mental health and learning disability services should equally be

able to access the recommended evidence-based treatments and to have choice and information regarding such treatments.

Recommendations have been made in relation to this.

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 recommendations made following the announced inspection on 10 and 11 May 2011

No.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	It is recommended that the RMO discusses and records restrictions/implications and any concerns around the detention process with patients.	The inspectors reviewed care documentation on the days of the inspection. The inspector found that patients consultant, medical and nursing staff had discussed assessment and treatment including, where appropriate, detention under the Mental Health (Northern Ireland) Order 1986 with patients and addressed concerns patients had in relation to this.	Fully met
2	It is recommended that staff review the records of the patients' meetings to include actions and outcomes and that minutes are displayed on patients' notice board.	Patient meetings were held on the ward on a fortnightly basis. The patient advocate attends these meetings. The inspector found that that the minutes of these meetings and actions agreed were available to patients on the ward.	Fully met
3	It is recommended that restrictions on use of personal electronic equipment are clearly explained to patients and advocates when appropriate. This should be documented in care plans.	Patients who met with inspectors stated that electrical items including razors and phone chargers that had been removed from them upon their admission. The reasons why these items were removed had been explained to them and that they could access these items upon request. Patient care documentation reviewed by inspectors evidenced that the removal of personal electrical items had been individually assessed and was proportionate to the risk identified.	Fully met
4	It is recommended that the Trust review the organisation and function of the MDT meeting to clarify roles and responsibilities and ensure best use of staff time and that this is completed in a timely manner.	Patients on the ward have the opportunity to attend their multi-disciplinary ward round which is held every Thursday although inspectors were informed by patients and staff that few patients opted to attend. Patients also met with their consultant on a weekly basis and the consultant is	Fully met

		available on the ward every morning Monday to Friday. Patient notes reviewed by the inspectors, evidenced that patients were involved in decisions regarding their treatment and care. Patients who met with inspectors were aware of the members of the multidisciplinary team and their role.	
5	It is recommended that the Trust review the management of consultant visits and MDT meetings for outlying patients to ensure a patient centred focus.	There is one consultant on the ward who carries consultant responsibility for every patient on the ward regardless of geographical area that patient is admitted from.	Fully met
6	It is recommended that consultant psychiatrists review the current practice and interview all patients in private weekly.	Patients on the ward met with their consultant privately on a weekly basis and the consultant is available on the ward every morning Monday to Friday.	Fully met
7	It is recommended that a multidisciplinary audit of case notes is conducted. This should include medical staff who appear not to be adhering to standards.	Audit of patient information was facilitated through the wards file maker system. Audits had not been completed recently as information regarding patients from locations outside the ward's catchment area was not available on the file maker system. The Trust was in the process of introducing a new patient information system. This recommendation has been amended and restated for a second time.	Not met
8	It is recommended that the environment is assessed with a view to improving ventilation, soundproofing and privacy.	There were no concerns in relation to privacy, ventilation or soundproofing on the ward raised by patients or identified by staff on the days of the inspection.	Fully met
9	It is recommended that all staff are up to date with mandatory training.	The inspectors reviewed training records for staff working on the ward on the days of the inspection. The inspector	Partially met

		found that all staff working on the ward on the days of the inspection had undertaken their mandatory training. Training records detailed that all staff had completed child protection training, infection control training and fire extinguisher training. Inspectors were informed that the ward had recently appointed six new members of staff who were in the process of completing l their mandatory training This recommendation has been restated for a second time.	
10	It is recommended that the Trust urgently review the interpretation and implementation of the comprehensive risk assessment.	This recommendation was made following the May 2011 inspection as it was noted that comprehensive risk assessments were not being completed and reviewed by members of the multidisciplinary team. The comprehensive risk assessment and management plans reviewed by inspectors on the days on the inspection had been completed and reviewed by the multidisciplinary team.	Fully met
11	It is recommended that the full potential of the gym as a treatment resource is realised and methods to improve uptake, including flexible working arrangements between the nominated staff are explored.	Staff reported that access to the gym for patients was limited as a number of nominated staff no longer worked on the ward. Inspectors were advised that arrangements to train staff to use this equipment were currently being discussed. Patients on the ward continue to utilise the gym when available and staff promote opportunities for patients to attend. This recommendation has been restated for a second time.	Not met
12	It is recommended that the Trust review current practices and seek to fully utilise the skills, competence and experience of staff.	Inspectors were informed that the senior staff nurse working on the ward had been trained in cognitive behaviour therapy (CBT) at post-graduate level. While the	Not met

		nurse stated that this informed their approach, these skills were not specifically utilised the nurse in day to day practice. This recommendation has been restated for a second time.	
13	It is recommended that measures are taken to increase collaboration with medical staff.	Three members of staff who met with inspectors and two of the twelve questionnaires received pre inspection indicated that nursing staff felt that medical staff did not listen to nursing opinions, that concerns raised by staff were dismissed by medical staff and that medical staff on the ward did not take account of nursing opinions. The inspector discussed these findings with the clinical acute services manager and the senior staff nurse. The inspector raised concerns regarding the potential impact this could have on patient care and treatment, decision making within the multi-disciplinary team and ward staff morale. Both staff members expressed concern regarding these findings and stated that this would be discussed and reviewed by the senior management team and the ward staff team. This recommendation has been restated for a second time.	Not met

Appendix 1

Follow up on the implementation of any recommendations made following the Patient Experience Interviews undertaken on 3 December 2013

No.	Reference.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	6.3.2	It is recommended that the ward manager ensures that information relating to the availability of advocacy service is given to patients on admission and recorded in their care documentation.	The inspector reviewed care documentation on the days of the inspection. There was evidence within the care documentation reviewed that patients receive information regarding advocacy service available to them on admission. The role of the patient advocate and guidance on how to access advocacy was also available in the patient information folder which located in each patients bedroom, and on posters on the ward.	Fully Met
2	5.3.1	It is recommended that the Trust review the smoking shelter for the ward to ensure that it provides significant cover for the patients.	The Trust carried out a review of the smoking shelter and consulted patients. As a result of the review and the implementation of a new DHSSPSNI smoking policy the current shelter has remained unchanged. The ward management team will continue to review smoking arrangements for patients to ensure these are appropriate and in accordance with Trust policy and procedure.	Fully met

Appendix 1

Follow-up on recommendations made at the finance inspection on 6 January 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 are listed appropriately, the area of their storage or transfer recorded, and appropriate receipting undertaken, particularly when relatives remove items from the ward.	The inspector reviewed the ward processes for ensuring the security of patient property and noted that patient valuables were listed on admission. The inspector did not find evidence of a process to record all items brought into the ward. This recommendation will be restated for a second time.	Partially met
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 the reason for access	A register of all staff permitted to access the safe was and a record of all staff who had obtained the key to the safe with a list of all safe transactions was available on the days of the inspection.	Fully Met
3	It is recommended that the Trust develops and implements a uniform policy for managing patients' finances within the Bluestone Unit, including managing and securing patients' property held in the ward safes.	The inspector was informed that a procedure for managing patient's money and property had been drafted and had been sent to the Trust's finance department for advice and guidance. However, at the time of the inspection this had not been implemented. This recommendation will be restated for a second time.	Partially met

Appendix 1

Follow-up on recommendations made following the unannounced inspection on 7 April 2014

No.	Reference.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	6.3	It is recommended that the Trust reviews the composition of and clinical specialities offered within the multidisciplinary team, and the availability of psychotherapeutic interventions to ensure that patients on the ward have access to the full range of evidence based therapeutic interventions to meet presenting needs.	Compliance with this recommendation was not formally assessed during this inspection as the agreed timescale for implementation of the recommendation was 31 July 2014. Inspectors did evaluate the availability of psychotherapeutic interventions as part of this inspection. The findings of this are included in the inspection report and new recommendations have been made in the quality improvement plan accompanying this report. This recommendation will be formally assessed at a future inspection of this service.	Not assessed
2	6.3	It is recommended that the Trust ensures that where long-term staff leave occurs, contingency arrangements are put in place to ensure that patients on the ward have appropriate access to the full range of clinical specialties and therapeutic interventions.	Compliance with this recommendation was not formally assessed during this inspection as the agreed timescale for implementation of the recommendation was 31 July 2014. This recommendation will be formally assessed at a future inspection of this service.	Not assessed
3	5.3	It is recommended that the Trust ensures that all members of the multi-disciplinary team record all actions in the patients' care documentation and use this information to update patient's	Patient information and care documentation was being updated by staff on the ward in a number of locations to include file maker, datix databases, patient file. The patient's comprehensive risk assessment and management plan were also available.	Fully met

		comprehensive risk assessment and management plan.		
4	5.3	It is recommended that the ward sister ensures that all staff are aware of the actions to be taken in relation to incorporating the views of patients and their family in care and treatment planning.	Nursing staff who met with the inspector detailed awareness of the need to ensure that the views of patients and their family were incorporated in the patient's treatment and care planning. Patients who met with the inspectors reported that they had been able to involve their carer/family in their treatment. Four of the five relatives/carers who returned questionnaires detailed that they had been offered the opportunity to be involved in decisions in relation to their relatives care and treatment on the ward.	Fully met
5	5.3	It is recommended the Trust ensures that all staff have received training and are aware of their responsibilities in relation to reporting incidents under the Health and Social Care Board Procedure for the Reporting and Follow up of Serious Adverse Incidents (October 2013).	Compliance with this recommendation was not formally assessed during this inspection as the agreed timescale for implementation of the recommendation was 31July 2014. This recommendation will be formally assessed at a future inspection of this service.	Not assessed
6	5.3	It is recommended that the Trust ensure that a policy, procedure and guidance documentation is available for staff in relation to ensure patient contact and interviews with PSNI are undertaken appropriately and safely, particularly in terms of	A policy and procedure and guidance in relation to interviews with the PSNI and in compliance with the Police and Criminal Evidence (Northern Ireland) Order 1989 was not available on the ward on the day of the inspection. This recommendation will be restated for a second time.	Not met

		patients' capacity to consent to the interview processes and to comply with the Police and Criminal Evidence (Northern Ireland) Order 1989 (PACE).		
7	5.3	It is recommended that the Trust ensures that all staff working within Cloughmore are clear of their roles and responsibilities in the event of a child protection concern.	Staff who met with the inspector had a clear understanding of their role and responsibilities in the event of a child protection concern. The ward's social worker and child protection nurse provided ongoing support, information and advice to staff in relation to any child protection concerns.	Fully met

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 care and treatment is monitored and reviewed by the MDT through 1:1 assessment with individual members of the team. At the MDT meeting the patient's mental state is discussed along with the patient's ability to consent to treatment, which is recorded in the multidisciplinary notes. Patients are given time following the weekly ward round to discuss any changes to their care and treatment with their primary nurse and resulting changes are recorded in the patients care plan. Where a patient does not have capacity, all appropriate steps are taken to improve functional abilities to enable decision-making. We also regularly provide updates about the patient's care treatment and management to their representative. The patient also has access to the advocacy service who feedback the patient's views and opinions to the MDT. The Trust has the following two documents in place to support decisions regarding capacity to consent, The Capacity Assessment Tool and The Best Interest Pathway for Adults who lack Capacity to Consent. All patients on admission are provided with the information leaflet "Consent it's up to you".	Ward manager to complete 4

Inspection Findings: FOR RQIA INSPECTORS USE Only	
Patients' records reviewed by inspectors provided evidence that patient progress, including ongoing assessment of patient's mental health status and capacity to consent, was being continually review by the multi-disciplinary team. Information for patients and their relative/carer regarding capacity and decision making was available. A patient information folder was accessible in each patient's room. The folder was appropriately presented and contained information regarding patient's rights. This included information explaining a patient's right to consent to treatment and the process followed when a patient cannot consent to care and treatment. In circumstances where a patient could consent staff used the "Best interests pathway capacity assessment tool" which was in keeping with DHSSPSNI guidance. At the time of the inspection all patients on the ward had been assessed as having capacity to consent to their care and treatment. Information regarding patients article eight (private and family life) and article fourteen rights (free from discrimination) was available to patients and staff on the days of the inspection. Patients who met with the inspectors reported no difficulties in accessing contact with their family. The ward had a child visiting policy and a room away from the main ward where visits from children could be facilitated. Patients were supported by members of the multidisciplinary team to understand their care and treatment through 1:1 and group sessions. The names of each patient's primary nurse were displayed daily on the noticeboard in the ward's dining area. Inspectors met with five patients all of whom reflected an understanding of why they were in hospital. Patients were invited to attend the multi-disciplinary ward round held every Thursday although inspectors were informed, by patients and staff, that few patients opted to attend. Patients met with their consultant on a weekly basis and the consultant was also present in the ward every morning Monday to Friday. Patient notes reviewed by the inspectors, evidenced that patients were involved in decisions regarding their treatment and care.	Compliant

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 assessment carried out on admission, which identifies the patients care needs. A MDT care plan is then developed with all patients and signed as an accurate reflection of the individual assessment by the patient, the MDT and if appropriate the nearest relative. Implementation of Promoting Quality Care ensures patient safety is paramount and the risk assessment and management plan is completed on all patients. All patients have individual nursing care plans. We identify communication needs through the assessment process and have when required the availability of an interpreting service and sign language service. An advocate is also available to liaise information to the MDT regarding the patients concerns and views. Assessment of need is regularly reviewed at the MDT meeting and participation is sought and evidenced from patients and their representatives and documented in the ward round sheet and MDT. As part of the recent QIP for Cloughmore an audit has been introduced to regularly review a sample of patients notes to ensure records are appropriately maintained.	Ward manager to complete 3

Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
On the days of the inspection there were 18 patients on the ward. The youngest patient was aged 26 years and the oldest was aged 75 years. Patients who met with the inspectors reported that they had been given the opportunity to be involved in their care and support and had been able to involve their family. Patients reports were positive about their experiences of the ward and were also positive regarding the commitment of staff. Two patients detailed concerns about the lack of clinical psychological support available. One patient had a history of post- traumatic stress and the second patient had been admitted as a result of an eating disorder. Inspectors discussed patient responses with the ward's medical, nursing and social work staff. Staff informed inspectors that that there was no psychology service available for patients on the ward. A recommendation has been made in relation to this. The ward utilised a number of systems to record and retain patient information. Recording systems included the file finder and datix databases and handwritten notes. The ward provided care for patients from a particular catchment area with the Trust. Records for these patients were retained on the file maker system. However, the ward also occasionally provides care for patients living outside the ward catchment area. Inspectors were informed that records for patients living outside the catchment area were handwritten as these patients were not registered on the file maker system. Inspectors reviewed care documentation and noted that medical staff were not updating the file finder or datix databases. Inspectors reviewed two files on the file finder system and noted that medical staff had not updated patient discharge plans. Although this information was available in the patient's hardcopy file inspectors were concerned that information in relation to patient care and treatment was being stored in two different locations. Inspectors discussed the ward's recording systems with the clinical acute services manager and the senior staff nurse. Inspectors were advised that the Trust was in the process of introducing the Paris system across all ward's within the Bluestone Unit to help ensure that patient treatment and care records were retained in one centralised recording system. A recommendation has been made.	Moving towards compliance

Patient files reviewed by inspectors contained multi-disciplinary notes and updated information regarding patient treatment including care plans and risk assessments. Two files were noted to be bulky and to contain information that had not been properly secured. Inspectors found that the information within patient files was not always chronologically ordered and some information had not been placed in the appropriate corresponding section. A recommendation has been made. On closer examination of both files inspectors noted: File 1: The patient had been admitted to the ward four days previously. The patient had been detained in accordance to the Mental Health (Northern Ireland) Order 1986. An admission proforma, risk screening tool, admission checklist and a mental health services assessment form had been completed. However, the patient's risk assessment had not been fully completed. Sections including information related to the patient's personal details, other indicators of risk, contingency plans and further action necessary had been left blank. The patient's signature was also missing which may have been explained by the fact that they had only recently been admitted. A recommendation has been made. The patient had also been assessed using a nutritional care plan, a falls risk assessment and a manual handling risk assessment. A nursing care plan on admission, an initial multi-disciplinary care plan and a prepopulated core care plan had also been completed. The patient had signed their nursing care plan. File 2: This patient had experienced three admissions to the ward during the previous three years. The patient's care documentation contained an up to date comprehensive assessment, multi-disciplinary team review minutes, progress notes and ongoing risk assessments. The patient's comprehensive risk assessment (RA2) was available and this had been completed on the 13/03/2012. Inspectors noted that subsequent patient risk assessments had been completed and updated during the periods the patient was on the ward.	

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:	
Cloughmore has a weekly timetable of therapeutic and recreational activities available to patients. These are carried out by the nursing staff and the OT on an individual and group basis. Examples of this include the gym, the walking group, self-care group, relaxation, mental health awareness and education groups. A record of this is maintained in a therapy book and participation is recorded in the patient's notes. Patients can influence the types of activities via the patient/staff meetings.	Ward manager to complete 4
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
Patients who met with the inspectors stated that their contact with the nursing and medical staff was positive. Patients indicated that they could speak with nursing staff as required and they had weekly contact with their consultant psychiatrist. The notice board in the ward's dining room detailed each patient's named nurse. There was also information regarding the ward's social worker and the patient staff meeting. The ward's therapeutic programme included activities that were available Monday to Friday such as relaxation sessions, art classes, a walking group, baking sessions, computer class, medication education sessions and a	Moving towards compliance

quiz. Patients could also access the Bluestone patient library on Monday mornings between 10.30am and 12 noon. Activities were facilitated by the ward's occupational therapist, supported by nursing staff, and took place in the morning and the afternoon every day Monday to Friday. The OT room was bright, clean and airy. The room displayed patient's work and this was noted to be varied with patients being able to choose to participate in a range of arts and crafts activities. The room also had a notice board detailing a wide range of information relevant to patients. This included information regarding coping strategies in easy read format. There was also a wide selection of information leaflets available and a notice explained that these could be accessed upon request to the OT. Activities provided by the nursing staff were also available. The ward's therapies book included a record of the activities that had been provided and the names of the participants. Inspectors reviewed the dairy and noted that during April there were no recorded activities. Entries for May recorded six activities ranging from a group walk lasting 70 minutes to a dance exercise class lasting 25 minutes. Activities provided in June increased to 14 although five of the activities were cancelled and the entry in the therapies book detailed that this was because staff had been "unable to facilitate group due to ward situation/busy ward". Staff who met with the inspectors reported that they were only able to provide activities if there was appropriate staffing on the ward. Staff explained that although there were appropriate numbers of staff available for each shift activities could be cancelled due to nurses having to prioritise other care and treatment duties including patient observations and completing patient admission and discharges. A recommendation has been made. Inspectors noted that the activities provided were designed to include all patients and not specific to individual assessed needs. Patients who met with the inspector reflected that they enjoyed ward activities. Patients were complementary regarding the occupational therapist and of the efforts made by nursing staff to provide activities.	

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 to patients on admission or as soon as their mental state allows. Any reason for delay will be recorded in the multidisciplinary notes. Detained patients specific rights are delivered both verbally and as written information appropriate to their understanding by the primary nurse. The ASW will also give an explanation to detained patients regarding their rights. The Bluestone Information Booklet has been developed. This incorporates information in relation to patients' rights, expectations regarding care and treatment and responsibilities. The admission checklist for detained patients prompts staff to ensure that rights are read to patients on each occasion of change in status and staff sign accordingly. Patients are supported in making applications to the Mental Health Review Tribunal by medical, nursing and social work staff. On admission or as soon as the patients mental state allows them to receive and discuss information on the name and role of their advocate. Advocates are present on the ward on a Tuesday and Thursday and are contactable by the patient or as requested by the patient with staff assistance. The advocate also attends the staff/patient meeting on a fortnightly basis. Patients are provided with appropriate information about what they can expect in their care and treatment and how to comment or complain. Patients are encouraged to complete the patient experience survey during their	Ward manager to complete 4

admission where they can make suggestions or comments about their care.	
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
There was 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 for patients on the ward. Patients could also access ward information folders which were 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 and the responsibilities of the ward staff team. Information regarding the patient advocacy service and the availability of the advocate was posted in the patient's dining area. The advocate was available to meet with patients on Tuesdays and Thursdays and could be contacted as required. Inspectors were informed that the advocate also attended the patient/staff meeting which was held every two weeks. One patient who met with inspectors stated that they had been supported by the advocate and this had been "very helpful". Two patients stated that they were unaware as to who the advocate was although both reflected that this may have been explained to them during their admission. Both patients stated that they would know who to talk to if they were unhappy. The notice board in the patient's dining room displayed information regarding the human rights act. Specific information regarding patient's rights was also available. This included information on a patient's right to consent and make decisions about their treatment, and the right to involve their family/carer in their care and treatment. Questionnaires returned to the inspectors by relatives/carers reflected that the ward promoted family/carer involvement. The dining room notice board also displayed information and contact details regarding a local carer and relatives support group. There was also a poster detailing how patients could make a complaint. Patients who met with the inspectors explained that they understood why they were in hospital and stated that they felt that staff were supportive and respectful.	Compliant

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**
All patients in Cloughmore are cared for in the least restrictive means. Patients who require restrictive practice due to the risk of harm to themselves, others or for protection of their dignity have clear coherent care plans that have been discussed and implemented with the MDT, the patient and their representative. As care plans are responsive to change they are regularly reviewed with the MDT, the patient and their representative. The Trust has introduced training through the Clinical Education Centre on deprivation of liberty and will be rolled out to all staff commencing in July 2014.	Ward manager to complete 3
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	

Patients who met with the inspectors stated that they had not experienced blanket restrictions during their admission. Patients explained that items including razors and phone chargers had been removed from them upon their admission. The reasons that these items were removed had been explained to patients and patients could access the items upon request. Patient care documentation reviewed by inspectors evidenced that the removal of personal items had been individually assessed and was proportionate to the risk identified. The entrance doors to the ward were locked but patients could leave the ward by asking the staff to unlock the doors. A sign detailing that the ward operated a locked door policy was posted on the ward's main entrance doors. Inspectors reviewed the ward's processes for recording and reporting the use of restraint. 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 system. Inspectors were informed that to complete this task nursing staff had to scan the handwritten restraint form, 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. Inspectors were informed 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. Staff who met with the inspectors relayed an understanding of restrictive practices and their implications in relation to patient rights The use of restrictive practices was individually assessed and this was reflected in patient treatment and care records. Patient continuous notes evidenced that nursing and medical staff monitored the use of restrictions on a daily basis. Staff who met with inspectors stated that they felt the ward promoted a least restrictive practice environment. One patient who met with the inspector reported that they had previously received enhanced observations. The patient detailed no concerns regarding their experience of this and stated that staff had explained the reason observations were being used. Patient care records demonstrated staff awareness and understanding of patient rights. Inspectors noted entries that evidenced nurse/patient conversations regarding family contact, explanation of ward procedures and patients right to reply and a patient's right to have their treatment reviewed. 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 patient's had the opportunity to express their opinions and concerns.	Substantially compliant

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:	
At the MDT and daily patient planning meetings criteria for discharge, estimated date of discharge and transfer of care to the Home Treatment Team are discussed with the patient and their representatives and signed as an accurate reflection in the ward round sheet. Nursing staff are trained in WRAP and the recovery model and aim to utilise this approach with patients from the point of admission. Delays in discharge are monitored and audited by the Patient Flow and Bed Management Coordinator. These are reported as part of statutory returns.	Ward manager to complete 3
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
Inspectors found that the multi-disciplinary team (MDT) met weekly and all professions working with the ward	Moving towards

attended. This included the consultant psychiatrist, staff grade psychiatrist, nursing staff, a representative from the home treatment team, a representative from the community mental health team, the ward's occupational therapist and the ward's social worker. Three members of staff who met with inspectors and two questionnaires received pre inspection (twelve returned) reported that a number of ward nursing staff felt that medical staff did not "listen" to nursing opinions. One nurse commented that "Concerns from nursing staff regarding patient care and wellbeing are dismissed, at times, by medical staff". Another nurse reported that "… nursing staff feel that their opinion and input regarding patient care is not taken into account by the medical staff on the ward". The inspector discussed these findings with the clinical acute services manager and the senior staff nurse. The inspector highlighted these concerns regarding the potential impact this could have on patient care and treatment, decision making within the multi-disciplinary team and ward staff morale. Both staff members expressed concern regarding these findings and stated that this would be discussed and reviewed by the senior management team and the ward staff team. A recommendation has been made. Evidence regarding discharge planning was available in patient files and on the file maker system. The discharge proforma available on the file maker system was comprehensive and appropriately detailed. However, as previously stated the discharge plans generated on this system were not fully completed as medical staff did not use the file maker system. When viewed in conjunction with patient's hard copy care records the inspector noted that discharge information from all disciplines was available. Discharge plans were discussed and agreed by the multi-disciplinary team (MDT) and the discharge proformas reviewed by inspectors evidenced patient and carer involvement. Discharge planning for patients not residing in the ward's catchment area was completed in the same way albeit using a different proforma. A recommendation regarding the ward's information systems has already been made. Five questionnaires returned by relatives/carers indicated that two relatives/carers had been aware of the patient's discharge plan, two had not been aware and one did not know if a discharge plan had been completed. Discharge planning with patients was completed through one to one contact with the patient and their family/carer, continued review by the MDT and via ongoing liaison with the community teams. Patients who met with the inspectors reported no concerns in being able to involve their family/carer in their care and treatment. Relative/carer involvement in patient discharge planning was also evidenced in the ward's discharge proforma. However, given the views shared by relatives regarding discharge, the concerns raised by staff in relation to communication within the multi-disciplinary team, and the use of different discharge proformas, inspectors concluded that the ward's discharge planning procedure was not robust. A recommendation has been made.	compliance

Inspectors were informed by the patient flow and bed manager that three patient had had their discharge from the ward delayed. The manager explained that patients subject to a delayed discharge were reported to the Health and Social Care board. Inspectors noted that one patient was being discharged the same week and the remaining two patients were to be discharged the following week. Staff who met with inspectors reported that the involvement of representatives from the community mental health and home treatment in the weekly multi-disciplinary team meeting had helped support patient discharge planning.	
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

The Regulation and Quality Improvement Authority

Quality Improvement Plan

Announced/Unannounced Inspection

Cloughmore Ward, Bluestone

2 and 3 July 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 clinical acute services manager and the senior staff nurse 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.

Recommendations made following inspection on 2 and 3 July 2014

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
1	5.3.1.	It is recommended that the Trust ensures that all staff are clear regarding their roles and responsibilities in maintaining up to date patient records and that records are maintained in one location and subject to audit.	2	Immediate and ongoing	From the acute governance forum the head of service has introduced a regular audit to review a sample of MDT notes to ensure records are appropriately maintained and all disciplines entries monitored. A working group has been set up to guide staff in their roles and responsibilities in recording and maintaining records. This will be audited quarterly.
2	5.3.3	It is recommended that all staff receive up to date with mandatory training and that records are available on the ward.	2	30 September 2014	The ward sister will strive to ensure that mandatory training is up to date. The ward sisters' support will continue to maintain a training database and alert when training is due. The ward sister will monitor this through KSF and supervision in accordance with the trust standards.
3	5.3.3	It is recommended that the full potential of the gym as a treatment resource is realised and methods to improve uptake, including flexible working arrangements between the nominated staff are explored.	2	31 August 2014	There is a Band 3 N/A trained as a gym supervisor in Cloughmore ward, she has weekly protected time to encourage patients participation.

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
4	5.3.3	It is recommended that the Trust review current practices and seek to fully utilise the skills, competence and experience of staff.	2	Immediate and ongoing	The ward is developing a proposal to utilise the participation of staff in evidence based practice in psychological interventions using the skills and expertise of the staff.
5	5.3.3	It is recommended that measures are taken to increase collaborative working across all disciplines in the multidisciplinary team including medical staff.	2	Immediate and ongoing	The trust has a working well policy were staff have to effectively participate in team working. The ward will continue to facilitate senior nurse and medical team meetings to help address concerns.
6	5.3.3	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.	2	Immediate and ongoing	The ward complies with the trusts patient property guidance. As part of the admission procedure all valuables are now documented within the MDT notes.
7	6.3.1	It is recommended that the Trust develops and implements a uniform policy for managing	2	31 August 2014	Local policies and procedures remain in development stage. The ward keeps a weekly inventory of items within the ward

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
		patients' finances within the Bluestone Unit, including managing and securing patients' property held in the ward safes.			safe and is audited on a monthly basis.
8	5.3	It is recommended that the Trust ensure that a policy, procedure and guidance documentation is available for staff in relation to ensure patient contact and interviews with PSNI are undertaken appropriately and safely, particularly in terms of patients' capacity to consent to the interview processes and to comply with the Police and Criminal Evidence (Northern Ireland) Order 1989 (PACE).	2	Immediate and ongoing	The trust will develop and implement policy and procedures guidance for staff on this issue in partnership with the PSNI.
9	6.3	It is recommended that the Trust reviews the composition of and clinical specialities offered within the multidisciplinary team, and the availability of psychotherapeutic interventions to ensure that patients on the ward have access to the full	1	31 July 2014	In current climate Psychology services are depleted across all areas of mental health services and at this time it is not possible to secure Psychology services for the inpatient unit.

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
		range of evidence based therapeutic interventions to meet presenting needs.			
10	6.3	It is recommended that the Trust ensures that where long-term staff leave occurs, contingency arrangements are put in place to ensure that patients on the ward have appropriate access to the full range of clinical specialties and therapeutic interventions.	1	31 July 2014	The Head of service will continue to review the staffing should long term leave occur, within the trust guidelines for contingency cover and ensure the remaining resource is utilised as efficiently as possible.
11	5.3	It is recommended the Trust ensures that all staff have received training and are aware of their responsibilities in relation to reporting incidents under the Health and Social Care Board Procedure for the Reporting and Follow up of Serious Adverse Incidents (October 2013).	1	31 July 2014	Incident reporting refresher training has been provided to nursing staff and the trust will continue to provide updates in the future as new staff start. The ward sisters/charge nurse have also reviewed the follow up of an incident as an SAI.
12	5.3.1	It is recommended that the ward manager ensures that patient files are appropriately maintained in chronological order, that all documentation contained within	1	Immediate and ongoing	The trust is implementing the PARIS CIS system and is currently being rolled out throughout the services. The system will ensure easier access to information required.

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
		the file is secured and stored as per the Northern Ireland Data Protection Act 1998.			
13	5.3.1	It is recommended that the Trust reviews the procedure for reporting the use of physical interventions and ensures that staff can complete these on the ward's information system	1	30 September 2014	This has been escalated to the trust governance team to ask for the physical intervention form to be added to datix system.
14	5.3.3	It is recommended that the Trust ensures that the views of all disciplines are considered and recorded to ensure safe and effective multidisciplinary care and clinical decision making.	1	Immediate and ongoing	All of the members of the MDT are encouraged to share their assessment at the MDT meetings and evidence this in the MDT notes and weekly ward round sheets. The ward sister will continue to monitor this at supervision. The audit of notes will monitor the evidence of MDT working.
15	5.3.1	It is recommended that the multi-disciplinary team reviews the discharge policy and procedure and ensures that patient discharges are completed in accordance with the required standards.	1	31 August 2014	The trust is implementing a new MD recovery plan to promote the development of patient centred care this will be incorporated within the PARIS system.
16	6.3	It is recommended that the Trust review access to the range of low intensity and high intensity	1	31 March 2015	The ward sister, SSN and bed manager are proposing a plan to senior management to incorporate and improve the availability of psychological interventions within existing

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
		Psychology Society (BPS).			
18	6.3	It is recommended that the Trust ensures that training and supervision in the range of low intensity psychological interventions as recommended by NICE, the CCQI, RCPsych and BPS should be available to nursing and other appropriate mental health staff working with patients on the ward.	1	31 March 2015	Also in relation to 16, the proposal being drawn up incorporates the availability of supervision from psychology. In the interim period the ward sister and SSN will continue to supervise nursing staff who deliver therapeutic interventions within the ward.
19	5.3.3	It is recommended that the Trust ensures that a range of therapeutic activities are available for patients on the ward. These activities should be available at throughout the day and at weekends and evenings. Activities should not be cancelled due to deficits in staff resources.	1	1 October 2014	The ward offers a weekly timetable which includes recreational and educational activities for patients during the day, evenings and weekends by nursing staff and the OT. This is always facilitated as per timetable unless unplanned changes to the ward environment occur and staff have to prioritise and use resources to manage risk on a temporary basis.

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	Lynsey Erskine
NAME OF CHIEF EXECUTIVE / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Maureen M-Quade

	Inspector assessment of returned QIP	Yes	No	Inspector	Date
A.	Quality Improvement Plan response assessed by inspector as acceptable	x		Alan Guthrie	5 October 2014
B.	Further information requested from provider				