The Regulation and Quality Improvement Authority

Cloughmore

Bluestone Unit

Craigavon Area Hospital

Southern Health and Social Care Trust

Unannounced Inspection Report

14 – 17 September 2015

npm national preventive mechanism

informing and improving health and social care

www.rqia.org.uk

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Our Vision, Purpose and Values

Vision

To be a driving force for improvement in the quality of health and social care in Northern Ireland

Purpose

The Regulation and Quality Improvement Authority (RQIA) is the independent health and social care regulator in Northern Ireland. We provide assurance about the quality of care, challenge poor practice, promote improvement, safeguard the rights of service users and inform the public through the publication of our reports.

Values

RQIA has a shared set of values that define our culture, and capture what we do when we are at our best:

- **Independence** - upholding our independence as a regulator
- **Inclusiveness** - promoting public involvement and building effective partnerships - internally and externally
- **Integrity** - being honest, open, fair and transparent in all our dealings with our stakeholders
- **Accountability** - being accountable and taking responsibility for our actions
- **Professionalism** - providing professional, effective and efficient services in all aspects of our work - internally and externally
- **Effectiveness** - being an effective and progressive regulator - forward-facing, outward-looking and constantly seeking to develop and improve our services

This comes together in RQIA's Culture Charter, which sets out the behaviours that are expected when employees are living our values in their everyday work.

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1.0 Introduction

The Regulation and Quality Improvement Authority (RQIA) is the independent health and social care regulator in Northern Ireland. We provide assurance about the quality of care, challenge poor practice, promote improvement, safeguard the rights of service users and inform the public through the publication of our reports.

RQIA's programmes of inspection, review and monitoring of mental health legislation focus on three specific and important questions:

Is Care Safe?

- Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them

Is Care Effective?

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

Is Care Compassionate?

- Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support

2.0 Inspection Outcomes

This inspection focussed on the theme of Person Centred Care

Person Centred Care

This means that patients are treated as individuals, with the care and treatment provided to them based around their specific needs and choices.

On this occasion Cloughmore has achieved the following levels of compliance:

Is Care Safe?	Partially met
Is Care Effective?	Partially met
Is Care Compassionate?	Met

3.0 What happens on Inspection

What did the inspector do:

- reviewed information sent to RQIA before the inspection
- talked to patients, carers and staff
- observed staff practice on the days of the inspection
- reviewed other documentation on the days of the inspection
- checked on what the ward had done to improve since the last inspection

At the end of the inspection the inspector:

- discussed the inspection findings with staff
- agreed any improvements that are required

After the inspection the ward staff will:

- send an improvement plan to RQIA to describe the actions they will take to make the necessary improvements
- send regular update reports to RQIA for the inspector to review

4.0 About the Ward

Cloughmore is an 18 bedded admission ward in the Bluestone Unit on the Craigavon Area Hospital site. The purpose of the unit is to provide acute assessment and treatment for patients with a psychiatric illness who require care in an inpatient environment. The multidisciplinary team consists of a team of nursing staff and health care assistants, a consultant psychiatrist, doctor, social worker and an occupational therapist. The trust is in the process of recruiting a clinical psychologist to work on the ward. There were 18 patients on the ward on the days of the inspection. Seven of these patients had been detained under the Mental Health (NI) Order 1986. A senior staff nurse was the nurse on charge on the days of the inspection.

5.0 Summary

5.1 What patients, carers and staff told inspectors

During the inspection patient representatives were asked to complete questionnaires. None of the patient representatives returned completed questionnaires.

During the inspection the inspector was able to meet with:

7 patients
0 carers
5 staff
1 advocate

Patients told inspectors that:

Staff listen to and respected their views and opinions and that they were involved in decisions about their care and treatment. Two patients stated that they were involved in some parts of their care and treatment plans but not all the time. One patient stated they were just told how their care was going to be delivered. Inspectors reviewed this patient's care records and there was evidence that staff had tried on numerous occasions to engage with this patient but they had refused.

Patients stated that staff had time to talk to them and they were offered reassurance when they were unhappy or feeling distressed. One patient stated that if they had a problem staff were always there to listen to them and give advice. One patient who was detained under the Mental Health (NI) Order 1986 stated that they were unhappy with their care and treatment. The inspectors reviewed this patient's care records and noted no concerns regarding their care and treatment. All seven patients who met with the inspectors stated that they were offered activities to take part in. Five patients stated that they felt being on the ward was helping them to recover. One patient stated that they were unsure if being on the ward was helping them to recover and one patient stated they did not feel being on the ward was helping them to recovery. All 7 patients who were interviewed by the inspectors stated that they felt safe and secure on the ward.

"*Nothing to recommend to change".…….Staff are good"*

"If you have a problem staff are always there to help and listen to you…..Staff are great at giving advice……Nurses are fantastic……Everyday I am getting better"

"Good standard of care"…I was in bad health when I was admitted but I now feel much better… The food is lovely…more physiotherapy would be good"

"In the past I was never told about my condition but I now know…Each day staff speak to me and tell me how I am progressing…I have been to loads of group sessions…….The ward environment is lovely it's like a hotel, ensuite rooms, lovely food, outdoor areas and great activities…once I got my anger and emotions sorted out I've been feeling great……bean bags would be good for the TV room for patients to relax in".

"The running of the ward is great…..Cleanliness……staff always find time to talk to you …..consultant needs to be more flexible and allow others to make decisions… the service been provided has been phenomenal"

Carers told inspectors that:

There were no carers available to speak with the inspectors and no questionnaires were returned

Nurses told inspectors that:

The inspectors spoke to three nurses on the ward. All three nurses raised concerns in relation to the partnership working within the multidisciplinary team. They raised issues in relation to their views not being heard or considered and they also felt that they were left to complete tasks that should be completed by the multidisciplinary team.

One of the nurses discussed how they had been part of the pilot on the ward to review low level intensity psychological interventions on the ward. It was good to note the nurses' enthusiasm in relation to how they can provide this level of intervention on the ward to assist in patient recovery.

The three nurses expressed concerns regarding the recruitment of experienced nurses to the ward and how difficult it is to retained experienced staff. They advised that seven staff members have recently resigned from their posts as they were successful in obtaining a higher position in the community

The Social Worker told the inspectors that:

They attend the weekly ward round and are on the ward each day. Their role involves supporting and advocating on behalf of/with patients. They are also involved in safeguarding referrals and sign post staff when there is the need to make child protection referrals. In relation to the MDT process they felt the partnership working had improved over the past year.

The consultant told the inspectors that:

New ways of working were being reviewed and that the trust was returning to the previous arrangement where the consultant had a community caseload and shared inpatient responsibility. The consultant indicated that because of time constraints the medical section of the ward round template had not been completed each week for patients

The ward advocate told the inspectors that:

The advocacy input has been established on the unit for some time and all patients are informed that they have access to an advocate. There was some concerns that the advocate is not routinely involved in ward rounds and most of the referrals to the advocate are from nursing staff.

See attached Appendix 2.

5.2 What inspectors saw during the inspection

The ward environment appeared clean, clutter free and odours were neutral. The furnishings throughout the ward were well maintained. Patients had their own ensuite bedrooms and they were available to patients throughout the day. However the walls throughout the ward clearly required to be repainted. There were a number of rooms available for patients to retreat to and patients were observed coming and going from the ward. The ward had a large garden area which was well maintained and had a goal post, basketball net and seated areas. The ward had a therapy room which displayed work the patients had carried out.

There was a visitor's room at the entrance to the ward and visitors could also come onto the ward to visit patients. Patients had access to their mobile phones and chargers unless an assessment indicated otherwise. There was also an interview room with a phone that patients could use.

Not all staff on duty was wearing their name badges and information about the nursing staff and the MDT team was not displayed. It was good to note the ward had an information booklet which was up to date however the ward did not have an operational policy in place. The inspectors did not observe any information displayed regarding Human Rights, the Mental Health Order and the MHRT. There was no information displayed regarding the days of the ward round or when the advocate visits the ward. However the advocate was on the ward on the day of the inspection and called to the ward every Tuesday and Thursday.

The ward displayed a comprehensive 'Ward Therapy Timetable' which included activities organised by the OT and low level intensity psychological interventions which the nurses on the ward delivered each week.

There were two profiling beds on the ward as both patients had a clinical need for this type of bed. However a risk assessment was not in place as agreed by the trust from the outcome of the previous inspection and only one patient had a care plan in place. However this had not been reviewed along with other care plans and had not been recorded on the PARIS system with all other care plans.

The inspectors observed positive interaction between staff and patients over the days of the inspection. Staff showed empathy and warmth towards patients and were prompt in responding to patients' requests. Staff were present in the communal areas and actively engaging with patients throughout the day. Staff appeared skilled at de-escalating situations when patients had become distressed and anxious.

The inspectors observed the ward advocate facilitate a group session with patients and this appeared to be very well represented. It was good to note that patients were actively engaging with the advocate.

See attached Appendices 3 and 4.

5.3 Key outcomes

5.3.1 Is Care Safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them

Compliance Level	Partially Met

See attached Appendix 5

What the ward did well

- ✓ Personal safety plans were completed for each patient and these were noted to be individualised, up to date and reviewed each week at the MDT ward round
- ✓ Personal safety plans were used to inform patients' personal well-being plans.
- ✓ The ward was clean, tidy and clutter free.
- ✓ Patients had access to a number of ward based facilities which included their own ensuite bedrooms, a large garden area, a therapy room and a number of communal rooms. They also had access to a gym and a coffee bar off from the main ward.
- ✓ The ward was a locked ward however patients who had not been detained under the Mental Health (Northern Ireland) Order 1986 where informed they could leave the ward
- ✓ Nursing staff had attended regular supervision meetings and had received appraisals with their line manager in the last year.
- ✓ Patients were informed how to make a complaint
- ✓ Staff attended to patients needs promptly when required
- ✓ There were enough staff available during the inspection to meet the needs of the patients on the ward.
- ✓ Patients said that staff had taken time to inform them of their rights and ensured they understood this process

✓ There were staff/patient meetings held fortnightly on the ward and the dates were displayed

Areas for improvement

Environmental safety

X The ward ligature risk assessment and action plan was in place which detailed controlled measures. However there was no timescale set for when recommendations would be completed. *Quality Standard 4.3(i)*

X Risk assessments were not in place for patients using profiling beds and only one patient had a care plan in place. However this had not been reviewed and had not been recorded on the PARIS system with all other care plans. *Quality Standard 5.3.1(a)*

X The ward required to be repainted *Quality Standard 5.3.1 (f)*

X The ward had completed an environmental/infection control audit however there were a number of areas identified in this as 'non-compliant' with specific actions required to address each area. However there was no record of a timeline for when these actions would be completed and who the responsible person was. *Quality Standard 4.3(i)*

X The ward had an up to date fire risk assessment completed and subsequent action plan however there was no record of the responsible person who would carry out these actions with a timeline for completion of this work. *Quality Standard 4.3(i)*

Patient care

X Patients were not involved in designing and managing their own personal safety plans. *Quality Standard 5.3.3(b)*

X Personal safety plan were not completed in line with the Promoting Quality Care - Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services May 2010. *Quality Standard 5.3.1(f)*

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Staffing

X The average number of banking shifts per week was 12 shifts. *Quality Standard 4.3.(n)*

X All staff did not have up to date mandatory training in place in accordance with the trust's corporate mandatory training policy dated March 2015. *Quality Standard 4.3.(m)*

Governance

X When patients are admitted to Cloughmore ward from another trust area all relevant patient information was not available to the MDT team to inform patients' care and treatment plans. *Quality Standard 8.3.(i)*

5.3.2 Is Care Effective?

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

Compliance Level	Partially Met

See attached Appendix 6.

What the ward did well

✓ Patients stated they were involved in their care and treatment

✓ Nurses met with each patient after the MDT meeting to discuss the patients care and treatment plans with them.

✓ Patients were provided with 1:1 therapeutic time each day and there was evidence that their care and treatment was discussed at these sessions

✓ There was evidence that patients' well-being plans were person centred and had been completed from assessed need and detailed appropriate interventions.

✓ In the four sets of records reviewed there was evidence that well-being plan included treatment goals, safety goals, family and social goals and health and lifestyle goals

✓ There was evidence of low intensity psychological interventions and recreational activities being carried out with these patients and progress records indicated how these patients had participated in each session.

✓ There was evidence of the implementation of low level psychological therapeutic interventions by staff on the ward

✓ There was evidence of a range of care and treatment options planned for patients which were delivered in line with current evidence based guidance and standards.

✓ A comprehensive therapy timetable had been devised for the ward which included low level psychological intervention groups and recreational groups. It was good to note that this timetable had been devised by both the occupational therapist (OT) and the nurses.

✓The Bluestone Unit were in the process of recruiting a clinical psychologist

✓ There was evidence that discharge planning had commenced early and appropriate community supports had been discussed with patients and their relatives

✓The ward was a locked ward however patients who were not detained under the Mental Health (Northern Ireland) Order 1986 were aware they could speak with a staff member if they wanted to leave the ward.

✓There was evidence that the MDT reviewed patients detention regularly to ensure patients were experiencing the least restrictive option with their care and treatment and patients were approved leave off the ward when this was agreed at the MDT meeting.

✓Deprivation of liberty (DOLS) Care plans were in place which explained the rationale in relation to the locked door on the ward.

✓All seven patients who met with the inspectors advised that they met with nursing staff each day to discuss their care and treatment and any concerns they might have. They also advised that after the MDT meeting they were updated on the agreements that were made and were given the opportunity to see their reviewed personal well-being plans

✓ An advocate from NIAMH attended the ward twice a week (Tuesday and Thursday)

✓All seven patients who met with the inspectors stated that they were offered activities to take part in.

Areas for improvement

Personal well-being plans

X There did not appear to be a link between patients' assessed need and the therapeutic interventions they were attending. Therapeutic care plans were not comprehensively completed from each patient's assessed need. *Quality Standard 5.3.1(a)*

X Patients did not attend their MDT meetings each week therefore decisions were made without their involvement. *Quality Standard 5.3.3(b)*

X Therapeutic and leisure activity care plans were not completed from assessed need and a number stated. 'To involve in therapeutic activity' without identifying which therapeutic invention the patients should attend. *Quality Standard 5.3.1(a)*

X The medical section of the ward round template had not been completed each week for patients. Sections on agreed actions and the timeframe for implementation were also not completed in all records reviewed. *Quality Standard 5.3.1(f)*

X DOL's care plans were not on the PARIS System but were held in patient's files. The inspectors noted that these care plans had not been reviewed along with the care plans on the PARIS system *Quality Standard 5.3.1(a)*

X Fifteen of the policies and procedures sent to RQIA prior to the inspection had been created prior to 2011 and therefore had not been reviewed within the last four years. *Quality Standard 5.3.1(f)*

X The ward does not have an operational policy in place. *Quality Standard 5.3.1(f)*

X A number of nursing staff raised concerns regarding their relationship with the medical staff. These staff members stated they felt their opinions were not taken on board and that they had been left to complete tasks which in their opinion should be completed by the multi-disciplinary team. *Quality Standard 8.3.(e)*

5.3.3 Is Care Compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support

Compliance Level	Met

See attached Appendix 7

What the ward did well

✓Staff gained consent prior to any intervention/care and treatment.

✓Patients met with nursing staff each day to discuss their care and treatment

✓There was evidence of best interest decisions made within the multidisciplinary team (MDT) which were reviewed regularly.

✓If patients required an interpreter this was facilitated

✓Patients attended meetings with their family when discussing discharge arrangements.

✓Patients stated staff listen to and respect their views and opinions and that they are involved on all decisions about their care and treatment

✓Staff used patients preferred name.

✓Blanket restrictions were in place in relation to the locked door on the ward. Patients who were not detained under the Mental Health (Northern Ireland) Order1986 were aware they could leave the ward

✓Deprivation of liberty (DOLS) Care plans were in place which explained the rationale in relation to the locked door on the ward and other restrictions.

✓There was evidence in the patients' care records that they could refuse their care and treatment and these decisions were respected.

✓The Inspectors observed staff responding promptly to patients' who appeared distressed and anxious

✓Patients stated that staff always had time to talk to them and they were always offered reassurance when they were unhappy or feeling distressed

✓ Patients reported no concerns in being able to express their spiritual and cultural wishes.

Areas for improvement

X There was no evidence that patients were attending or given a choice to attend their MDT meetings each week. *Quality Standard 5.3.3(b)*

X Information on the ward performance was not displayed, all staff were not wearing their name badges, there was no information displayed on the MDT team, the day of the ward round, the patients named nurse/keyworker or who was on duty including the doctor. *Quality Standard 6.3.2(b)*

X There was no information displayed on Human Rights, the advocacy service, the Mental Health Order or the MHRT *Quality Standard 6.3.2(b)*

6.0 Follow up on Previous Inspection Recommendations

Nine recommendations were made following the last inspection on 23 April 2015. The inspector was pleased to note that seven recommendations had been implemented in full. Two recommendations were not met and will be restated for a second time. These recommendations are in relation to the ward manager ensuring that all patients who use a profiling bed have a clear rationale in their care records supported by a risk assessment and care plan. Additionally the trust reviews the procedure for obtaining information when patients are admitted to the ward from another trust area.

See attached Appendix 1

7.0 Other Areas Examined

7.1 Serious concerns

RQIA wrote to the trust following the inspection on the 17 September 2015. There were a number of concerns that required to be address as a priority. The trust was asked to submit an action plan to RQIA by 21 October 2015 addressing the following concerns.

- Reviewing of policies and procedures
- Deficits in mandatory training
- Communication difficulties within the multidisciplinary team
- Out of area admissions

8.0 Next steps

Areas for improvement are summarised below. The Trust, in conjunction with ward staff, should provide an improvement plan to RQIA detailing the actions to be taken to address the areas identified.

	Area for Improvement	Timescale for implementation in full
Priority 1 recommendations		
1	Risk assessments were not in place for patients using profiling beds and only one patient had a care plan in place. However this had not been reviewed and had not been recorded on the PARIS system with all other care plans. *Quality Standard 5.3.1(a)*	16/10/15
Priority 2 recommendations		

1	Fifteen of the policies and procedures sent to RQIA prior to the inspection had been created prior to 2011 and therefore had not been reviewed within the last four years. RQIA have requested an action plan in relation to this recommendation. *Quality Standard 5.3.1(f)*	21/10/15
2	All staff did not have up to date mandatory training in place in accordance with the trust's corporate mandatory training policy dated March 2015. RQIA have requested an action plan in relation to this recommendation. *Quality Standard 4.3.(m)*	21/10/15
3	A number of nursing staff raised concerns regarding their relationship with the medical staff. These staff members stated they felt their opinions were not taken on board and that they had been left to complete tasks which in their opinion should be completed by the multi-disciplinary team. RQIA have requested an action plan in relation to this recommendation. *Quality Standard 8.3.(e)*	21/10/15
4	When patients are admitted to Cloughmore ward from another trust area all relevant patient information was not available to the MDT team to inform patients' care and treatment plans. RQIA have requested an action plan in relation to this recommendation *Quality Standard 8.3.(i)*	21/10/15
5	The ward had an up to date fire risk assessment completed and subsequent action plan however there was no record of the responsible person who would carry out these actions with a timeline for completion of this work. *Quality Standard 4.3(i)*	21/10/15
6	The medical section of the ward round template had not been completed each week for patients. Sections on agreed actions and the timeframe for implementation were not completed in all records reviewed. *Quality Standard 5.3.1(f)*	21/10/15
7	The ward ligature risk assessment and action plan was in place which detailed controlled measures. However there was no timescale set for when recommendations would be completed. *Quality Standard 4.3(i)*	13/11/15
8	Patients did not attend their MDT meetings each week therefore decisions were made without their involvement. *Quality Standard 5.3.3(b)*	13/11/15
9	Personal safety plan were not completed in line with the Promoting Quality Care - Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services May 2010. *Quality Standard 5.3.1(f)*	13/11/15

10	The ward had completed an environmental/infection control audit however there were a number of areas identified in this as 'non-compliant' with specific actions required to address each area. However there was no record of a timeline for when these actions would be completed and who the responsible person was. *Quality Standard 4.3(i)*	13/11/15
11	Patients were not involved in designing and managing their own personal safety plans. *Quality Standard 5.3.3(b)*	11/12/15
12	There did not appear to be a link between patients' assessed need and the therapeutic interventions they were attending. Therapeutic care plans were not comprehensively completed from each patient's assessed need. *Quality Standard 5.3.1(a)*	11/12/15
13	Therapeutic and leisure activity care plans were not completed from assessed need and a number stated. 'To involve in therapeutic activity' without identifying which therapeutic invention the patients should attend. Quality Standard 5.3.1(a)	11/12/15
14	DOL's care plans were not on the PARIS System but were held in patient's files. The inspectors noted that these care plans had not been reviewed along with the care plans on the PARIS system *Quality Standard 5.3.1(a)*	11/12/15
15	Information on the ward performance was not displayed, all staff were not wearing their name badges, there was no information displayed on the MDT team, the day of the ward round, the patients named nurse/keyworker or who was on duty including the doctor. *Quality Standard 6.3.2(b)*	11/12/15
16	There was no information displayed on Human Rights, the advocacy service, the Mental Health Order or the MHRT *Quality Standard 6.3.2(b)*	11/12/15
Priority 3 recommendations		
1	The ward required to be repainted *Quality Standard 5.3.1 (f)*	18/3/16
2	The average number of banking shifts per week was 12 shifts. *Quality Standard 4.3.(n)*	18/3/16
3	The ward does not have an operational policy in place. *Quality Standard 5.3.1(f)*	18/3/16

Definitions for prority recommendations

PRIORTY	TIMESCALE FOR IMPLEMENTATION IN FULL
1	This can be anywhere from **24 hours to 4 weeks from the date of the inspection** – the specific date for implementation in full will be specified
2	Up to **3 months** from the date of the inspection
3	Up to **6 months** from the date of the inspection

Appendix 1 – Previous Recommendations

Appendix 2 – PEI Questionnaires
This document can be made available on request

Appendix 3 – Ward Environmental Observation Tool
This document can be made available on request

Appendix 4 – Quality of Interaction Schedule
This document can be made available on request

Appendix 5 – Is Care Safe?
This document can be made available on request

Appendix 6 - Is Care Effective?
This document can be made available on request

Appendix 7 - Is Care Compassionate?
This document can be made available on request

Appendix 1

Follow-up on recommendations made following the unannounced inspection on 23 April 2015

No.	Reference.	Recommendations	No of times stated	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	6.3.1	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.	3	The inspectors reviewed the trust's policy and procedure for managing patients' private property which was issued in May 2015. This policy included the management of patients' finances within the Bluestone Unit, including managing and securing patients' property held in the ward safe. Cloughmore does not currently have a safe on the ward.	Met
2	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.	2	The inspectors reviewed recent incidents which were recorded on the DATIX system and there was evidence that all information in relation to each incident was recorded on this system. However, this procedure still involves the nursing staff having to scan the physical intervention form to their own email and then copying it into the DATIX system which is very time consuming. Senior trust representative stated at the feedback meeting held on the 17/9/15 that the IT dept were working on a non-live mock up model to be tested on the DATIX system which should eliminate the need for staff to scan the physical intervention form.	Met
3	4.3 (i)	It is recommended that the ward manager ensures that all patients who use a profiling bed	1	The ward currently has two profiling beds. The inspectors reviewed the care documentation in relation to these two patients. The risks	Not met

		have a clear rationale in their care records supported by a risk assessment and care plan.		associated with the patients using theses beds had not been recorded in the patients' comprehensive risk assessment (CRA) which had been agreed by the trust in the previous QIP. Only one of the patients had a care plan in place in relation to the use of a profiling bed. However this had not been reviewed since 27 July 2015 and was recorded in a paper copy and not included in the PARIS system with all other care plans.	
4	5.3.1 (c)	It is recommended that the ward manager reviews the location and arrangements for the safe storage of patients' property to ensure that access to patients' property and belongings is only accessible by authorised staff.	1	This recommendation was in relation to the storing of patients' mobile phones and chargers on the open ward. This practice has now changed as patients have access to their chargers unless there has been an identified risk in relation to their access to these items. If risks are identified patients have an individual risk management plan in place. On the day of the inspection patients who had a mobile had these on their possession with their charger.	Met
5	8.3 (c)	It is recommended that the Trust reviews and implements a robust process for obtaining patient information for patients transferred from other trusts to the wards in the Bluestone Unit to ensure that all relevant patient information is promptly available to inform care and treatment	1	There was no evidence of a robust system in place for obtaining information for patients who have transferred from another trust to the bluestone unit. Nurses on the ward who spoke to the inspectors expressed concerns regards the lack of information they receive when they accept patients from another trust area. The PARIS systems in each trust is not compatible so information cannot be received via this	Not met

		plans**.**		process. Given the concerns raised by the inspectors with regard to a number of serious adverse incidents connected to the ward and the high levels of incidents on the ward it is concerning to note that patients are admitted onto the ward without the proper documentation to ensure of patients' safety. It was noted at the feedback meeting that this was not a concern specifically for Southern Trust and that it would be raised regionally by RQIA.	
6	6.3	It is recommended that the Trust ensure that Clinical Psychology is included in the multi-disciplinary team not only to provide specialist psychological therapies, but also to assist in the training and supervision of low and high intensity interventions delivered by other professionals as recommended by the National Institute of Clinical Excellence (NICE), the College Centre for Quality Improvement (CCQI), The Royal College of Psychiatrists (RCPSYCH) and the British Psychology Society (BPS).	2	Inspectors were informed by senior trust representatives at the feedback meeting and in an email following this meeting that the trust had reviewed the need for psychology input and were in the process of recruiting a full time psychologist for the Bluestone Unit. There had been a delay in the recruitment of the consultant clinical psychologist as the funding offered was insufficient for the grade required. However, the trust has now agreed that the extra funding required will be met. The clinical psychologist will assist in the training and supervision of low and high intensity interventions which are delivered by other professionals.	Met
7	6.3	It is recommended that the Trust reviews the composition of and	2	The ward has reviewed the composition of and clinical specialities offered within the	Met

		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.		multidisciplinary team, and the availability of psychotherapeutic interventions. The trust has confirmed that they will be recruiting a psychologist to the bluestone unit. The ward has also completed a pilot on 'Improving the Delivery of Psychological Therapies within Acute Mental Health Wards in Bluestone'. The outcome from this pilot has been very positive with the ward now holding a number of low intensity psychological intervention sessions throughout the week. Staff nurses have been provided with training to ensure they can deliver therapeutic interventions on the ward and a number of staff are booked on training courses. **Cognitive Behaviour Therapy (CBT)** In relation to CBT 14 staff have been booked on the essential skills part of this course. One staff member has a Module in CBT and one member of staff has a certificate in CBT. Two staff members are due to commence the Certificate in CBT and one staff member has a Degree in CBT. **Counselling** Two members of staff have completed modules in counselling and one staff member has completed a Degree in counselling	

				Motivational Interviewing Three staff members are booked to attend the essential skills course on motivational interventions this year and nine are booked on this course for next year. One member of staff has completed this course. **Eating Disorders** Three staff members have completed a post-graduate certificate in eating disorders and five staff have completed CBT-E in eating disorders. The inspectors reviewed the timetable for the ward which included the psychological interventions arranged for each week (this was reviewed regularly) and recreational activities. There was evidence that the ward was providing patients with a wide range of evidence based therapeutic interventions and recreational activities to meet presenting needs. The groups held included: Recovery groups: Hope, Personal Responsibility, Education, Self-advocacy, support. Understanding Anxiety/CBT Managing Anxiety Understanding Depression/CBT Managing Depression/low mood Challenging/Managing Emotions	

				Understanding Addictions Discharge recovery focus Psychological stages of change and therapeutic benefits of change Cycle of change –'loss and gains of my addiction' Belief Group Psychological Maintenance and relapse prevention (Alcohol)Medication Education Sleep hygiene Increase your self esteem Problem solving group Recovery, Personal, Responsibility Group Walking groups Beauty Playing cards Cinema outings Reading newspaper/magazines Breakfast club Exercise and music A file is held on the ward which details who attends each session and if patients have refused to attend this is also recorded	
8	6.3	It is recommended that the Trust review access to the range of low intensity and high intensity psychological interventions, for patients being treated in hospital, as recommended by the National	2	The ward is currently providing patients with low intensity psychological interventions. Senior trust representatives have confirmed that when a psychologist is recruited to the Bluestone unit in the coming weeks high intensity psychological interventions will be available to patients who	Met

		Institute of Clinical Excellence (NICE), the College Centre for Quality Improvement (CCQI), The Royal College of Psychiatrists (RCPSYCH) and the British Psychology Society (BPS).		require this level of support.	
9	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.	2	The ward sister and a senior staff nurse continue to provide supervision to nursing staff who are delivering low level therapeutic psychological interventions. Senior representatives within the trust have confirmed that when a psychologist is recruited to the bluestone unit in the coming weeks they will be providing staff with supervision. As detailed in recommendation 7 staff are registered to attend a number of low level intensity psychological training courses and this is being continually reviewed.	Met

Appendix 1

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

No.	SAI No	Recommendations	Action Taken (confirmed during this inspection)
1	SAI 29655	For cases known to multiple providers of Mental Health/ Addiction Services the inpatient Multidisciplinary team (MDT) should conduct an enhanced discharge meeting	The inspectors were informed that all complex cases known to multiple providers have an enhanced discharge planning meeting held.
2	SAI 29655	The trust should clarify with the HSCB/ Associate Medical Director of Primary Care if a protocol exists for patients who have moved out of a GPs geographical catchment area but still remain on the GPs caseload.	Senior trust representative stated at the feedback meeting held on 17 September 2015 that contact had been made with HSCB and currently no protocol is in place
3	SAI 29655	The hospital social work / ASW Coordinator should liaise with the RESWS in relation to the feasibility of the RESWS having access to the NI. ECR.	The ASW coordinator informed the inspectors that they have liaised with RESWS and plans are in place for RESWS to have access to the NI.ECR
4	SAI 29655	The issue of searching patients for potential weapons should be raised at the next PSNI / Mental Health Services Liaison Forum in September 2014.	The ASW coordinator informed the inspectors that this meeting has been held and the trust have written to the PSNI.

HSC Trust Improvement Plan

WARD NAME	**Cloughmore**	**WARD MANAGER**	**Lynsey Erskine**	**DATE OF INSPECTION**	**14-17 September 2015**
NAME(S) OF PERSON(S) COMPLETING THE IMPROVEMENT PLAN	Lynsey Erskine	**NAME(S) OF PERSON(S) AUTHORISING THE IMPROVEMENT PLAN**		FRANCIS RICE	

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

The areas where improvement is required, as identified during this inspection visit, are detailed in the inspection report and improvement plan.

The completed improvement plan should be completed and returned to team.mentalhealth@rqia.org.uk from the HSC Trust approved e-mail address, by 6 November 2015.

Please password protect or redact information where required.

PRIORTY	TIMESCALE FOR IMPLEMENTATION IN FULL
1	This can be anywhere from **24 hours to 4 weeks from the date of the inspection** – the specific date for implementation in full will be specified
2	Up to **3 months** from the date of the inspection
3	Up to **6 months** from the date of the inspection

Part A

Priority 1: Please provide details of the actions taken by the Ward/Trust in the timeframe **immediately** after the inspection to address the areas identified as **Priority 1**.

Area identified for Improvement	Timescale for full implementation	Actions taken by Ward/Trust	Attached Supporting Evidence	Date completed
Key Outcome Area – Is Care Safe? Risk assessments were not in place for patients using profiling beds and only one patient had a care plan in place. However this had not been reviewed and had not been recorded on the PARIS system with all other care plans **Minimum Standard 5.3.1(a)** This area has been identified for improvement for the **first** time	30/09/15	The safe use of Avant Garade Beds has been on the Trust Risk Register since 22/2/10 and is reviewed regularly. Risk assessments were in place for both patients occupying profile beds, please see attachment. The care plan that was reviewed on the day of inspection by the inspectors did have the use of profiling beds documented in other section and had been reviewed on 15/9/15, please see attachment. Due to the transition to electronic recording there was difficulty in navigating the system which led to the evidence not being made available on the day of inspection. The Trust is supporting staff to become increasingly familiar with the system and ensure that there is consistency in where the risk and management is recorded. The ward sister has provided guidance to all staff in relation to the recording of the use of profiling beds. This will be monitored alongside the weekly care plan audit which is overseen by the Ward Sister	Trust Risk Register Comprenhensive Risk assessments x2 Recovery Care Plan x1	

Key Outcome Area – Is Care Effective? None of the areas for improvement identified as a result of this inspection are required to be completed within this priority				
Key Outcome Area – Is Care Compassionate? None of the areas for improvement identified as a result of this inspection are required to be completed within this priority				

Part B

Priority 2: Please provide details of the actions proposed by the Ward/Trust to address the areas identified for improvement. The timescale within which the improvement must be made has been set by RQIA.

Area identified for improvement	Timescale for improvement	Actions to be taken by Ward	Responsibility for implementation
Key Outcome Area – Is Care Safe? All staff did not have up to date mandatory training in place in accordance with the trust's corporate mandatory training policy dated March 2015. RQIA have requested an action	21/10/2015	Please see attachment with up to date training record. The training record will identify when staff have been booked for training and attended. This will be monitered monthly by the Ward Sister and any non compliance and reason will be escalated to the Head of Service. The Head of Service has requested additional dates for training to cater for the new staff recently recruited.	

plan in relation to this recommendation **Minimum Standard 4.3.(m)** This area has been identified for improvement for the **first** time			
The ward had an up to date fire risk assessment completed and subsequent action plan. However there was no record of the responsible person who would carry out these actions with a timeline for completion of this work. **Minimum Standard 4.3(i)** This area has been identified for improvement for the **first** time	21/10/2015	Please see attched document with recommendations completed.	
The ward ligature risk assessment and action plan was in place which detailed controlled measures. However there was no timescale set for when recommendations would be completed. **Minimum Standard 4.3(i)** This area has been identified for improvement for the **first** time	13/11/2015	Please see attached document with recommendations included.	
Personal safety plans were not completed in line with the Promoting	13/11/2015	Please see document attached Procedure for Acute Mental Health In-Patient Multidisciplinary Team Morning meeting.	

Quality Care - Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services May 2010. **Minimum Standard 5.3.1(f)** This area has been identified for improvement for the **first** time		The wards sister and Senior Staff Nurse have emphasised to all members of the MDT the importance of adhering to PQC guidance. This will be monitored alongside the weekly care plan audit which is overseen by the Ward Sister	
The ward had completed an environmental/infection control audit. However there were a number of areas identified in this as 'non-compliant' with specific actions required to address each area. However there was no record of a timeline for when these actions would be completed and who the responsible person was. **Minimum Standard 4.3(i)** This area has been identified for improvement for the **first** time	13/11/2015	The ward sister has provided guidance to the nursing assistants who undertake the monthly audit. The Ward Sister will review each audit carried out by the Nursing Assistants. This is then taken to a detailed audit carried out by the ward sister and Domestic supervisor on a monthly basis to idenfify any areas of non-compliance with actions and timescales to be completed.	
Patients were not involved in designing and managing their own personal safety plans. **Minimum Standard 5.3.3(b)** This area has been identified for	11/12/2015	Please see response to previous recommendation and attached document - Procedure for Acute Mental Health In-Patient Multidisciplinary Team morning meetings. The ward sister and Senior Staff Nurse have highlighted the importance of all members of the MDT following PQC guidance in relation to patient involvement.	

improvement for the **first** time		This will be monitored alongside the weekly care plan audit which is overseen by the Ward Sister	
Key Outcome Area – Is Care Effective? Fifteen of the policies and procedures sent to RQIA prior to the inspection had been created prior to 2011 and therefore had not been reviewed within the last four years. RQIA have requested an action plan in relation to this recommendation **Minimum Standard 5.3.1(f)** This area has been identified for improvement for the **first** time	21/10/2015	The Trust has provided a response to RQIA regarding this recommendation and all Policies and Procedures have now been reviewed and evidence sent to the lead inspector.	
A number of nursing staff raised concerns regarding their relationship with the medical staff. These staff members stated they felt their opinions were not taken on board and that they had been left to complete tasks which in their opinion should be completed by the multi-disciplinary team. RQIA have requested an action plan in relation to this recommendation. **Minimum Standard 8.3.(e)**	21/10/15	This recommendation has been escalated to senior line managers both in the medical and nursing disciplines. Work is progressing both on an individual and team level to improve working relationships. The Head of Acute Mental Health Services and the Associate Medical Director have met with the Consultant and the Ward Sister to explore the issues and ways forward to ensure safe and effective Team work. The Ward Sister has identified clear roles and responsibilities for the Multidisciplinary Team meetings and the Daily Patient Planning Meetings and communicated these to all members of the MD Team. A number of Team Building exercises are being concidered by the Head of Service, with the Service Improvement Facilitator,	

This area has been identified for improvement for the **first** time		for the team. The Ward Sister, Senior Staff Nurse and the Ward Consultant will meet monthly to review progress and the outcome will be reported to Head of Service and Associate Medical Director.	
The medical section of the ward round template had not been completed each week for patients. Sections on agreed actions and the timeframe for implementation were also not completed in all records reviewed. **Minimum Standard 5.3.1(f)** This area has been identified for improvement for the **first** time	21/10/15	Please see attachment - Procedure for Acute Mental Health In-Patient Multidisciplinary Team morning meetings document. Both documents have been discussed and agreed by all members of the MDT to achieve this recommendation.	
Patients did not attend their MDT meetings each week therefore decisions were made without their involvement. **Minimum Standard 5.3.3(b)** This area has been identified for improvement for the **first** time	13/11/15	Service user feedback has previously criticised this procedure which led the trust to change the Ward Round Procedure and not invite patients into the meetings. To ensure patient opinion each discipline present at the ward round will have seen the patient prior to the MDT meeting to offer feedback and share views. Following the ward round the nurse provides overall feedback to the patient. All patients are invited to attend family meetings and pre-discharge meetings. The ward sister will now ensure that all patients are offered the oppportunity to attend the ward round and a record of their decision documented in the intervention section in PARIS.	
There did not appear to be a link between patients' assessed need and the therapeutic interventions they were attending. Therapeutic care plans were not comprehensively completed from each patient's	11/12/15	The ward pilot on Improving the delivery of Psychological Therapies continues and has not been completed as documented by the inspectors in the report. The Ward sister and Senior Staff Nurse have provided guidance to the MDT to meet this recommendation. Please see attachment - Guidance for recommendations for Ward Psychological Therapies. This will be monitored alongside the	

assessed need. **Minimum Standard 5.3.1(a)** This area has been identified for improvement for the **first** time		weekly care plan audit which is overseen by the Ward Sister	
Therapeutic and leisure activity care plans were not completed from assessed need and a number stated. 'to involve in therapeutic activity' without identifying which therapeutic intervention the patients should attend. **Minimum Standard 5.3.1(a)** This area has been identified for improvement for the **first** time	11/12/15	Please see above Guidance in previous recommendation and exemplar for staff training.	
DOL's care plans were not on the PARIS System but were held in patient's files. The inspectors noted that these care plans had not been reviewed along with the care plans on the PARIS system **Minimum Standard 5.3.1(a)** This area has been identified for improvement for the **first** time	11/12/15	At the time of the inspection work was in progress regarding DOLS and the trusts new electronic recording system PARIS. All DOLS care plans are now recorded in PARIS.	
Key Outcome Area – Is Care Compassionate? Information on the ward performance	11/12/15	On the day of the inspection a number of new staff had recently commenced post. Their name badges have been ordered but to date have not yet arrived. The ward information board now identifies the MDT staff, the	

was not displayed, all staff were not wearing their name badges, there was no information displayed on the MDT team, the day of the ward round, the patients' named nurse/keyworker or who was on duty including the doctor. **Minimum Standard 6.3.2(b)** This area has been identified for improvement for the **first** time		ward round day and time and staff on duty each day. Pre and post inspection a named nurse allocation list is displayed in the patient area and on admission all patients are provided with a card identifiying their primary and associate nurse during their stay in hospital. Please see attached. RTTC as a process for continued improvement has not been implemented for over 18 months. The ward has been using IMROC as a method of implementing change to improve service delivery in a recovery focused way. Following service user and carer feedback the display of information on ward performance was removed from the open ward areas and displayed in the staff base. The display boards now have an empasis on recovery and the availability of psychological and recreational therapies within Cloughmore ward. The Ward has promoted the patient feed back and this is now collated and displayed in a public area of the ward.	
There was no information displayed on Human Rights, the advocacy service, the Mental Health Order or the MHRT **Minimum Standard 6.3.2(b)** This area has been identified for improvement for the **first** time	11/12/15	This information had been on display pre inspection however had been damaged by a patient and new posters had been ordered. The ward sister has ordered a stock of posters so they can be replaced immediately if damaged again in the future. This information is now on display in the patient areas.	

Part C

Priority 3: Please provide details of the actions proposed by the Ward/Trust to address the areas identified for improvement. The timescale within which the improvement must be made has been set by RQIA.

Area identified for improvement	Timescale for	Actions to be taken by Ward	Responsibility

	improvement		for implementation
Key Outcome Area – Is Care Safe? The average number of banking shifts per week was 12 shifts. **Minimum Standard 4.3.(n)** This area has been identified for improvement for the **first** time	18/3/16	Mr McMurray provided feedback to the inspectors regarding work force planning. There is an on-going recruitment process to fill vacancies as they arise.	
The ward needed repainted **Minimum Standard 5.3.1 (f)** This area has been identified for improvement for the **first** time	18/3/16	A works requisition has been completed and the Head of Service is progressing with this. The trusts estates department have given assurances to the director that outstanding works will be completed by April 2016. A meeting has taken place with managers from Estates to define timelines to operationalise work.	
Key Outcome Area – Is Care Effective? The ward does not have an operational policy in place. **Minimum Standard 5.3.1(f)** This area has been identified for improvement for the **first** time	18/3/16	The Patient Flow and Bed Management Co-ordinator with the Ward Sisters is progressing on developing an operational procedure for acute in-patient wards. The first draft will be discussed by the Acute inpatient team at the end of November for circulation, comment, redrafting and finalised through the Acute Governace meeting by 18 March stipulated by the Trust Improvement Plan.	

Key Outcome Area – Is Care Compassionate? None of the areas for improvement identified as a result of this inspection are required to be completed within this priority			

Part D

Outstanding Recommendations: Please provide details of the actions proposed by the Ward/Trust to address outstanding recommendations, identified at previous inspections. The timescale within which the improvement must be made has been set by RQIA.

Recommendation	Timescale for improvement	Actions to be taken by Ward	Responsibility for implementation
Key Outcome Area – Is Care Safe? All patients who were using a profiling bed did not have a record in their care documentation explaining the rationale for using this type of bed supported by a risk assessment and care plan **Minimum Standard 5.3.1(a)** This area has been identified for improvement for the **second** time.	30/09/2015	Please see comments in relation to recommendation 1	
The Trust had not reviewed and implements a robust process for obtaining patient information for	21/10/15	The Patient Flow and Bed Management Co-ordinator had reviewed the process locally and sought assurances from trusts requesting ECR beds to provide appropriate patient	

patients transferring from other trusts to the wards in the Bluestone Unit to ensure that all relevant patient information is promptly available to inform care and treatment plans**.** RQIA have requested an action plan in relation to this recommendation **Minimum Standard 8.3.(i)** This area has been identified for improvement for the **second** time.		information in a timely fashion. If this had not been happening it was to be escalated to the bed manager. Despite this review there are still some occassions when this information is not forthcoming. This has been escalated and there is now a regional working group from the adult mental health commisioning sub group led by Eithne Darragh from the HSCB to agree a regional protocal that all Trusts can sign up to. The HSCB have organised a workshop for 13 November 2015.	
Key Outcome Area – Is Care Effective? None of the areas for improvement identified as a result of this inspection are required to be completed within this priority			
Key Outcome Area – Is Care Compassionate? None of the areas for improvement identified as a result of this inspection are required to be completed within this priority			

TO BE COMPLETED BY RQIA

Inspector comment (delete as appropriate)	**Inspector Name**	**Date**
I have reviewed the Trust Improvement Plan and any attached evidence and I have requested further information.	Audrey McLellan	19/11/15
I have reviewed additional information from the Trust and I am satisfied with the proposed actions	Audrey McLellan	27/11/15