The Regulation and Quality Improvement Authority

RQIA

Mental Health and Learning Disability

Unannounced Inspection

Silverwood, Bluestone Unit, Craigavon Area Hospital

Southern Health and Social Care Trust

9 and 10 February 2015

npm national preventive mechanism

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Contents

1.0 General Information

Ward Name	Silverwood, Bluestone Unit
Trust	Southern Health and Social Care Trust
Hospital Address	Craigavon Area Hospital 68 Lurgan Road Portadown BT63 5QQ
Ward Telephone number	028 38334444
Ward Manager	Angeline Magennis
Email address	angeline.magennis@southerntrust.hscni.net
Person in charge on day of inspection	Angeline.Magennis – Ward Manager
Category of Care	Acute Mental Health Inpatient
Date of last inspection and inspection type	10 June 2015
Name of inspector	Kieran McCormick

2.0 Ward profile

Silverwood Ward is an acute admission ward for adult male and female patients and is situated within the Bluestone Unit on the Craigavon Area Hospital site. The ward provides single room accommodation for up to 18 patients. There were 18 patients on the ward on the day of the inspection and nine of these patients were detained under the Mental Health (NI) Order 1986. The purpose of the unit is to provide acute assessment and treatment for patients with a psychiatric illness who require care in an inpatient care environment.

Patients have access to the multi-disciplinary team which includes input from nursing, psychiatry, social work, occupational therapy and psychology. Patients on the ward have access to an independent advocacy service.

The ward maintains an access control door policy; on the days of inspection patients were observed leaving the ward following a request from staff.

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 concerns identified within this report and following the inspector of Silverwood ward were discussed with the senior managers from Bluestone Unit at a separate meeting with RQIA on the 23rd February 2015.

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

4.0 Review of action plans/progress

An unannounced inspection of Silverwood, Bluestone Unit, Craigavon Area Hospital was undertaken on 9 and 10 February 2015.

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 September 2013 were evaluated. The inspector noted that three recommendations had been fully met. However, despite assurances from the Trust, five recommendations stated for a second time had not been fully implemented and two recommendations stated for a first time had not been met. Five recommendations will require to be restated for a third time and two recommendations will be restated for a second time, in the Quality Improvement Plan (QIP) accompanying this report.

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

The recommendation made following the patient experience interview inspection on 10 June 2014 was evaluated. Despite assurances from the Trust, the only recommendation made had not been fully implemented and will require to be restated for a second time in the Quality Improvement Plan (QIP) accompanying this report.

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

The recommendations made following the finance inspection on 6 January 2014 were evaluated. The inspector noted that one of two recommendations had been fully met. However, despite assurances from the Trust, one recommendation had not been fully implemented and will require to be restated for a second time in the Quality Improvement Plan (QIP) accompanying this report.

5.0 Inspection Summary

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.

The inspector reviewed the care documentation for four patients and noted the following on the days of the inspection. There was minimal information available or displayed for staff and patients in relation to Capacity, Consent and Human Rights.

Care plans in three of the four patients files reviewed were individualised and person centred. In one of the four care files reviewed for a young person admitted to the ward the inspector noted that the care plans were not person

centred or individualised. The care plans in this case were generic core care plans. A recommendation has been made in relation to this. Care plans in each file had been signed on occasions by the patient or where they had not been signed an explanation had been inserted, however this was not consistent throughout each file reviewed. The inspector was not provided with any evidence that care plans not signed or for a patient unable to sign that an opportunity at a later date was provided for them to sign their care plans. A recommendation has been made in relation to this. It was positive to note that patients subject to detention had a detention care plan in place that provided an explanation of the individual's rights whilst detained. The detention care plan also evidenced that the patient's rights whilst detained had been explained and that information regarding detention was provided to the patient. In each of the patients' files, care plans did not provide guidance to staff on how to obtain or assess consent on an individual basis or the actions to take if consent was not obtained. The daily progress notes made no reference that patients were consenting or not to care and treatment on a daily basis. A recommendation has been made in relation to this.

Care documentation made no reference to the consideration of patients Human Rights Articles 8; to respect the right to family and private life and Article 14; the right to be free from discrimination. There was also no reference to patients' capacity to consent for care, treatment or invasive procedures within their care files.

In two of the patient care files reviewed the patient had an individualised and holistic MDT initial care plan created on admission, signed and dated in each case by the patient. Patients other care plans and assessments identified the individuals physical and mental health needs. However risk assessments and care plans were not consistently reviewed and evaluated throughout each patient's admission. The review of patients care plans provided no detailed explanation as to whether or not the aims of the care plan were being achieved and meeting the individual patient's needs. A recommendation has been made in relation to this.

The inspector reviewed two comprehensive risk assessments, one risk screening tool and a completed Functional Assessment of the Care Environment (FACE) risk assessment for the young person under the age of 18. In two of the patient's files the inspector noted that the comprehensive risk assessments were reviewed and completed in accordance with the Promoting Quality Care Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services May 2010. However the risk screening tool in the other adult file provided no indication as to the 'further action needed', the tool had not been signed or dated. A recommendation has been made in relation to this.

Patients care files reflected regular contact with medical staff and a minimum of once weekly one to one consultation with the consultant psychiatrist. For those patients that require review more often this is facilitated and was reflected in medical progress notes. The four care files reviewed by the inspector evidenced that each patient is reviewed weekly by the MDT. Care

documentation however made no reference to the consideration of patients Human Rights Articles 8; to respect the right to family and private life. A recommendation has been made in relation to this.

Patients' needs are reviewed weekly at the MDT meeting. The outcomes from MDT meetings were accurately and comprehensively completed. Actions identified at MDT meetings are allocated to a responsible person with an agreed completion date.

The inspector met with the ward Occupational Therapist (OT). All new admissions to the ward are reviewed by the OT and the MDT to determine the level of OT intervention required. If requiring OT input a patient will be provided with information in relation to the OT activities provided on the ward. In addition to this the OT will complete an individualised assessment based on the needs of each patient. This may include a combination of physical, functional and mental state assessments.

A review of patients' files evidenced that, where applicable, appropriate assessments had been completed with recommendations and outcomes clearly documented within the individual patients care file.

The OT informed the inspector of the variety of group and 1-1 activities and therapies provided. A review of patients care files reflected patient participation at activities clearly documented and recorded within the progress notes. A copy of the OT timetable was clearly displayed on the ward; in addition to this a ward based activity timetable was displayed. Patients who do not avail or engage with OT services receive activity input from the ward based timetable. A review of the ward activity file evidenced activities taking place in the evenings and at weekends, this included walking groups, board games, reading newspapers, outings for coffee and anxiety management group work. Ward staff are also able to access the OT activity room at all times.

The ward OT expressed concerns regarding the sharing of information between ward staff and the OT. This was discussed with the ward manager who agreed to ensure that the OT is invited to the monthly team meeting. The OT also expressed concerns in relation to OT staffing resources for the ward. The OT explained that due to being the only OT on the ward that this proved challenging in fulfilling all the therapeutic needs and potential for each patient. The OT explained that due to this pressure there was little opportunity to provide therapeutic 1-1 support to patients and to measure outcomes of therapeutic sessions.

Over the course of the two day inspection the inspector observed a number of group activities taking place. The inspector observed nursing and medical staff actively engage with patients, communication and interactions were positive.

The Bluestone Unit provides a gym for patient use. The inspector was informed that there was currently only one member of ward staff trained to facilitate patients' use of the gym. As a result patients are only able to receive

a limited opportunity to access the gym facilities. A recommendation has been made in relation to this.

The inspector was advised that patients in Silverwood have access to inpatient psychology services. Access to the service is achieved through a referral process.

Care documentation reviewed made no reference to the consideration of patients' Human Rights Articles 8; to respect the right to family and private life. However family and friends visiting Silverwood are welcome onto the main ward; a private room was available for visits. There was evidence in the patients care documentation of family contact either on the ward or whilst on home leave.

Information regarding the detention process, the mental health review tribunal, making a complaint, and access to independent advocacy services was available. A review of care files for patients subject to detention reflected a detention care plan in place relating to the Mental Health (Northern Ireland) Order 1986. The care plan detailed the rights of the individual whilst detained. In the same files there was evidence that patients had exercised their right of appeal to the Mental Health Review Tribunal.

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 on how to make a complaint and the patient advocacy service and their availability was displayed on the ward. The advocate was available to meet with patients on a Thursday and could be contacted as required.

A review of four patients care files did not reflect that information was clearly provided to patients regarding the ward door access control system and the removal of certain items such as sharps and phone chargers. It was not consistent or clear in each patients file that this information had always been provided. A recommendation has been made in relation to this. However a poster was displayed on the ward regarding the removal of certain items. Patients who met with the inspector expressed no concerns regarding the restrictions in place.

The ward operates a locked door policy; patients could not independently exit the ward, patients could leave the ward by asking the staff to unlock the doors

Care documentation reviewed by the inspector did not demonstrate that the use of blanket restrictions had been discussed and recorded in each individual patient's circumstance. Care documentation made no reference to the consideration of patients Human Rights 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; to respect the right to family, private life and Article 14; the right to be free from discrimination. The inspector was provided with no robust evidence that patients Deprivation of Liberty had been considered. A recommendation has been made in relation to this.

Bedrooms and sleeping areas were not locked on the days of the inspection.

Training records reviewed evidenced that 21 of the 25 staff working in Silverwood had received up to date training in physical interventions, those staff with expired training had been booked on a session due within the coming month.

Three of the four questionnaires which were completed by ward staff and visiting professionals prior to the inspection indicated that not all staff had received training in relation to restrictive practices. Staff who met with the inspector during the course of the inspection also stated that they had not received Deprivation of Liberty training. A recommendation has been made in relation to this.

The inspector met with the ward manager and consultant psychiatrist who provided an explanation of the discharge process. The inspector was advised that the multi-disciplinary team (MDT) met weekly, this provided an opportunity to review each patient's progress and to track those patients nearing or ready for discharge.

The ward consultant advised that preparation for discharge commences early in the admission. The MDT will review the patient's history, complete any necessary assessments and review the previous living arrangements. In preparation for discharge relevant information will be shared with the community team and/or Home Treatment Team and were necessary they will be invited to an MDT meeting prior to the patient's discharge.

The inspector was not provided with any evidence of a formalised discharge pathway however in two of the four patients' files reviewed there was evidence of discharge care plans commenced and in place to guide the patient's preparation for discharge. In the other two patients files the inspector did not observe any evidence of a discharge care plan to guide staff on preparing the patient for discharge or the steps to take in monitoring the patient's progress towards discharge. A recommendation has been made in relation to this.

The ward manager advised that patients whose discharge is delayed are escalated and reported accordingly to the patient flow and bed management co-ordinator, from this they are escalated to hospital directors and the Health and Social Care Board. The ward manager advised that there were two patients on the ward who were delayed in their discharge from hospital.

Patients who met with the inspector reported no concerns regarding the preparation for discharge process or being able to involve their family/carer in their care and treatment. One of the patients who met with the inspector was going on home leave during the days of the inspection. Care documentation made no reference to the consideration of patients Human Rights Articles 8; to respect the right to family and private life however the inspector reviewed evidence of work undertaken with nearest relatives and the patient to prepare for discharge.

During the course of the inspection the inspector observed a registered nurse spending 1-1 time with a patient discussing their care plan. Staff were familiar with individual patient needs, their likes, dislikes and choices. The three ward staff who met with the inspector demonstrated their knowledge of patients' communication needs.

The inspector met with two patients during the course of the inspection, none of the patients expressed any concerns in relation to involvement in their care and treatment. Patients were invited to attend the multi-disciplinary ward round held every Thursday although the inspector was informed that few patients opted to attend. Patients met with their consultant for a 1-1 consultation on a minimum once weekly basis, patients requiring it are seen more frequently, the consultant was also present on the ward everyday Monday to Friday. One patient expressed concerns regarding their detention and rights whilst detained, on review the patients records the patient had been provided with information in relation to their detention and rights whilst detained.

Details of the above findings are included in Appendix 2.

On this occasion Silverwood Ward has achieved an overall compliance level of **Moving Towards Compliance** in relation to the Human Rights inspection theme of "Autonomy".

6.0 Consultation processes

During the course of the inspection, the inspector was able to meet with:

Patients	**2**
Ward Staff	**3**
Relatives	**0**
Other Ward Professionals	**4**
Advocates	**0**

Patients

The inspector met with two patients during the course of the inspection. Patients who met with the inspector spoke positively regarding the staff on the ward. One of the patients expressed concerns in relation to personal matters pertaining to their care. The inspector discussed these matters with the patient and also with the ward manager. The inspector was satisfied following discussion with the ward manager and a review of the patients records. Patients who met the inspector confirmed that they receive one to one time with their named nurse and consultant. Patients stated:

“staff are excellent”

Relatives/Carers

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

Ward Staff

The inspector met with three members of nursing staff on the ward. Staff who met with the inspector confirmed their understanding and responsibilities for the safeguarding of patients. Staff also confirmed that they receive twice yearly supervision and an annual appraisal. Staff stated that they felt well supported and enjoyed working on the ward. Staff who met with the inspector confirmed that they had not received training on Deprivation of Liberty Safeguards, Capacity, Consent and Human Rights, this was discussed with the ward manager and a recommendation has been made in relation to this.

“staff work well as a team”

“the ward sister is brilliant”

Other Ward Professionals

The inspector met with four visiting ward professionals during the course of the inspection. Visiting professionals who met with the inspector expressed no concerns in relation to the care and treatment of patients on the ward. Professionals who met with the inspector were able to provide an explanation as to their role and function within the ward. One of the visiting professionals expressed concerns regarding the sharing of information; this was discussed with the ward manager who agreed to resolve the matter.

Advocates

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

Questionnaires

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

Questionnaires issued to	Number issued	Number returned
Ward Staff	20	1
Other Ward Professionals	5	3
Relatives/carers	18	2

Ward Staff

One questionnaire was returned by ward staff

The inspector noted that information contained within the staff questionnaire demonstrated that the member of staff was aware of the Deprivation of Liberty Safeguards (DoLS) – interim guidance. The staff member indicated that they had received restrictive practice training and were aware of restrictive practices on the ward. Examples of restrictive practices as reported by staff included “removal of objects with potential to cause harm” and “access off the ward”. The completed questionnaire indicated they had received training in the areas of Human Rights and capacity to consent.

The staff questionnaire returned stated they had received training on meeting the needs of patients who require support with communication and that patient communication needs are recorded in their assessment and care plan. The staff member reported that patients had access to therapeutic and recreational activities and that these programmes meet the individual patient’s needs.

Other Ward Professionals

Three questionnaires were returned by visiting ward professionals in advance of the inspection. It was noted that information contained within the professional's questionnaires reflected that they were unaware of the DoLS – interim guidance. The visiting professionals stated that they had not received training in the areas of restrictive practices, human rights, capacity and consent.

One of the three visiting professionals stated they had received training on meeting the needs of patients who require support with communication. All three questionnaires indicated that individual patients' communication needs are recorded in their assessment and care plan. The three professionals recorded that they were aware of alternative methods of communicating with patients and that these were used in the care setting.

Relatives/carers

Two relatives returned a questionnaire. Relative's comments included:

"limited access to consultants, doctors making decisions has greatly delayed treatment"

"mixed messages from different nurses each day has led to confusion in understanding treatment and progress"

7.0 Additional matters examined/additional concerns noted

Complaints

Prior to the inspection RQIA received a record of the number of complaints made between 1 April 2013 and 31 March 2014. The inspector reviewed the record of complaints held on the ward and in discussion with the ward manager clarified the details. The ward manager advised that all complaints had been fully investigated in accordance with policy and procedure; this was confirmed on review of the complaint records. A review of the complaints records indicated that there were currently no complaints against the ward. The complaints policy and procedures was available and is noted to be due for review July 2015. A review of records also evidenced commendations for the services provided to patients and families, this included thank you cards and donations. It was positive to note that the complaints procedure was also available in a number of different languages available throughout the ward.

Adult Protection Investigations

The inspector met with the ward manager and social work safeguarding lead to discuss the safeguarding activity on the ward. The social work lead advised that staff were robust, thorough and effective with the Safeguarding Vulnerable Adult procedures and were making appropriate referrals in accordance with policy and procedure.

There were no reported substantiated allegations received prior to the inspection. The inspector was advised that there were currently three referrals currently undergoing investigation. The inspector reviewed the Trust 'Safeguarding Vulnerable Adults Operational Procedure Guidance', the inspector could not evidence if the document had been reviewed since its expiry in September 2014. A recommendation has been made in relation to this. The operational procedure supports the Trust 'Adult Safeguarding and Protection Policy' the inspector requested a copy of the policy however the ward manager and Patient Flow and Bed Management Coordinator were unable to furnish the inspector with a copy. A recommendation has been made in relation to this.

A previous recommendation was made that the ward's vulnerable adult procedures are reviewed and that the role of the designated officer is not assigned to the ward manager. The inspector discussed this matter with the ward manager, social work safeguarding lead and the Patient Flow and Bed Management Coordinator. The inspector was advised that the ward manager continues to remain as the Designated Officer for the ward. In many circumstances the ward manager will also act as the Investigating Officer and the Designated Officer. The previous recommendation will therefore require to be restated for a **second** time.

Additional concerns noted

Profiling beds

A serious adverse incident resulting in a fatality concerning the use of a profiling bed as a ligature point occurred in 2013. In December 2013 The Health and Social Care Board requested that all HSC Trusts take appropriate actions in accordance with The Northern Ireland Adverse Incident Centre Estates and Facilities Alert EFA/2010/006. The exposed bed frame on the profiling beds on Silverwood presents the same level of risk associated with ligature points as was the case when the fatality occurred. A recommendation has been made in relation to this.

During the course of the inspection the inspector noted three profiling beds located within individual side rooms. The inspector was advised by ward staff that the beds were primarily used for those patients with assessed physical or mobility difficulties. However, ward staff advised that the beds may also be used for any patient, if they are the only beds available on the ward. The inspector reviewed the care file for the three patients using profiling beds. Patients care files provided no evidence of a clear and robust rationale, risk assessment or care plan for those patients using the beds. A recommendation has been made in relation to this.

Training

The inspector reviewed the training records for 25 members of the staff team. The inspector was concerned to note a gap in staff attendance at Child and adolescent mental health service training. A review of the staff training matrix

demonstrated only 11 (44%) of the 25 staff working on the ward had received CAMHS training since the last inspection. The ward manager advised that there are currently no further training dates available for this course. As a result this recommendation will require to be restated for a **third** time.

The inspector also noted concerns from the returned staff questionnaires, discussions with staff and review of the training matrix gaps in the provision of capacity, consent, restrictive practices, Deprivation of Liberty Safeguards and Human Rights. A recommendation has been made in relation to this.

Fire safety

The inspector was provided a tour of the ward at the commencement of inspection. The inspector noted that in one of the patient sleeping areas that the fire extinguishers had been removed from their location. The ward manager advised that these had been placed in the staff base due to a patient lifting them off the wall. The communication of their temporary relocation is recorded on the staff handover sheet. The ward manager advised that previously fire extinguishers have been used as a weapon; this has been escalated and added to the ward risk register. A recommendation has been made in relation to this.

Environmental issues

Two recommendations related to environmental concerns were restated for a second time following the inspection on 13 September 2013. These recommendations were related to the installation of ventilation in the sitting/quiet room and the repainting of the ward.

During the course of this inspection the inspector noted that ventilation had not been installed in the sitting/quiet room. On the days of inspection the room presented as warm and stuffy. The ward sister was able to provide evidence to the inspector that despite her many attempts at escalating the concerns to her line manager and the estates department, the matter had not been resolved. As a result this recommendation will require to be restated for a **third** time.

The inspector was informed that some of the communal areas had been repainted since the last inspection. However, the ward sister confirmed that patients' bedrooms and all of the communal areas had not been repainted despite many attempts at escalating these matters to their line manager and the estates department. As a result this recommendation will require to be restated for a **third** time.

In addition to the environmental concerns noted previously, the inspector noted a pungent smell present in a number of areas throughout the ward, particularly the Occupational Therapy room. The inspector also noted the vinyl flooring on the ward was 'bubbling' in a number of areas. Again the ward sister provided evidence of making ongoing efforts to have these concerns addressed by escalating to their line manager and the estates department. A recommendation has been made in relation to these matters.

8.0 RQIA Compliance Scale Guidance

Guidance - Compliance statements		
Compliance statement	**Definition**	**Resulting Action in Inspection Report**
0 - Not applicable	Compliance with this criterion does not apply to this ward.	A reason must be clearly stated in the assessment contained within the inspection report
1 - Unlikely to become compliant	Compliance will not be demonstrated by the date of the inspection.	A reason must be clearly stated in the assessment contained within the inspection report
2 - Not compliant	Compliance could not be demonstrated by the date of the inspection.	In most situations this will result in a requirement or recommendation being made within the inspection report
3 - Moving towards compliance	Compliance could not be demonstrated by the date of the inspection. However, the service could demonstrate a convincing plan for full compliance by the end of the inspection year.	In most situations this will result in a recommendation being made within the inspection report
4 - Substantially Compliant	Arrangements for compliance were demonstrated during the inspection. However, appropriate systems for regular monitoring, review and revision are not yet in place.	In most situations this will result in a recommendation, or in some circumstances a recommendation, being made within the Inspection Report
5 - Compliant	Arrangements for compliance were demonstrated during the inspection. There are appropriate systems in place for regular monitoring, review and any necessary revisions to be undertaken.	In most situations this will result in an area of good practice being identified and being made within the inspection report.

Appendix 1 – Follow up on Previous Recommendations

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

Appendix 2 – Inspection Findings

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

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

Appendix 1

Follow-up on recommendations restated following the announced inspection on 10 September 2013

No.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	It is recommended that there is a timeline for updating policies and procedures. (twice)	The inspector met with the ward manager and the Patient Flow and Bed Management Coordinator who stated that a timeline had not been created. In addition to this the inspector noted a number of policies and procedures that had no date of when they had been created or when they have been reviewed or due review.	**Not met**
2	The ward requires repainting. (twice)	The inspector noted a number of communal areas and patient bedrooms that required urgent repainting. The inspector met with the ward manager and the Patient Flow and Bed Management Coordinator who stated that the ward had not been repainted.	**Not met**
3	Recommended that the ventilation in the sitting room/quiet room is monitored by the estates department and rectified. (twice)	The inspector completed a tour of the ward during the inspection. The inspector visited the sitting/quiet room and noticed it to be warm and stuffy on the day of inspection. The inspector met with the ward manager and the Patient Flow and Bed Management Coordinator who stated that the ventilation had not been resolved.	**Not met**
4	Recommended that cupboards are provided within the cleaning store. (twice)	The inspector visited the cleaning store and observed a number of cupboards that had been installed since the last inspection.	**Fully Met**
5	Recommended that more staff are trained to enhance patients access to gym. (twice)	During the course of the inspection the inspector was informed that there was currently only one member of ward staff trained to facilitate patients' use of the gym. As a result patients have only a limited opportunity to access the gym facilities.	**Not met**
6	Child and adolescent mental health service. Training to be prioritised and issue reviewed. (twice)	The inspector was concerned to note that training records reviewed during the inspection demonstrated only 11 (44%) of the 25 staff working on the ward had received CAMHS training since the last inspection. The ward manager advised that there are currently no further training dates	**Not met**

		available for this course.	

Follow-up on recommendations made following the announced inspection on 10 September 2013

No.	Reference.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	18 Section 4, 4.4, part 3, page 8.	It is recommended that the ward's vulnerable adult procedures are reviewed and that the role of designated officer is not assigned to the ward manager.	The ward manager advised the inspector that they continue to remain as the Designated Officer for the ward. In many circumstances the ward manager will also act as the Investigating Officer and the Designated Officer.	**Not met**
2	2 Section 2, parts 13.1, 13.3 and 13.7, page 9-10.	It is recommended that patient signatures are available on all relevant assessment and care documentation. Staff should record when a patient has refused or been unable to sign.	The review of patients' records evidenced that the recording of patients' signatures or a reason for no signature was not consistent in any of the four patient files reviewed.	**Not met**
3	2 Section 1, parts 5.1-5.26, pages 3-5.	It is recommended that the Southern Trust provides continued mandatory training to ensure staff can remain up to date with their mandatory training requirements.	The inspector reviewed the ward training matrix and identified a rolling programme of activity for mandatory training. Staff training is reviewed and any individual needs are identified at supervision and appraisal sessions. In addition staff are responsible for identifying any training needs that they may have. Staff who met with the inspector expressed no concerns regarding accessing training courses.	**Fully met**
4	2 Section 1, part 4.14, page 3.	It is recommended that the ward staff meeting is reviewed and the frequency of meetings is commensurate to the needs of ward staff.	The inspector reviewed the records for staff team meetings. Records indicated that team meetings are held monthly in addition the ward communication book is used to communicate information to staff between meetings. A review of the team meeting minutes evidence those in attendance and matters arising.	**Fully met**

Appendix 1

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

No.	Reference.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	5.3.1 a	It is recommended that the ward manager ensures that patient care plans are developed in response to individual assessed needs, person centred and comply with published guidance and standards.	The inspector reviewed the care records for a young person under the age of 18. The inspector noted that the patients care plans were not person centred or individualised. Care plans had been created using a core generic format.	**Not met**

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 transferred recorded and appropriate receipting undertaken, particularly where relatives remove items from the ward.	The inspector reviewed the patient property book. The property book clearly recorded all items of value, patients are then provided with a receipt. The patient property book also had a record of items retained by the patient or if they are returned to a relative on admission.	**Fully met**
2	It is recommended that the Trust develops and implements a uniform policy for managing patient's finances within the Bluestone Unit.	The inspector met with the ward manager and the Patient Flow and Bed Management Coordinator who stated that the uniform policy for the Bluestone Unit has not been implemented. The managers advised that the policy was currently under review by senior hospital management and is awaiting final approval. The inspector was not provided a copy of the draft policy.	**Not 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)	Inspector's Validation of Compliance
1		N/A		

Quality Improvement Plan

Unannounced Inspection

Silverwood, Bluestone Unit, Craigavon Area Hospital

9 and 10 February 2015

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

The specific actions set out in the Quality Improvement Plan were discussed with the ward manager, deputy ward manger and the Patient Flow and Bed Management Coordinator on the day of the inspection visit.

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

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
1	5.3.1 (c)	It is recommended that there is a timeline for updating policies and procedures.	3	May 2015	The key policies and procedures identified have been reviewed and forwarded to the acute governance meetings for approval, which is scheduled for the 29th April 2015 other policies due for review will be completed by end May 2015
2	5.3.1 (f)	The ward requires repainting.	3	31 July 2015	This has been escalated through the Assistant Director and again restated through estates. The ward sister will continue to raise this matter until completed.
3	5.3.1 (f)	It is recommended that the ventilation in the sitting room/quiet room is monitored by the estates department and rectified.	3	31 July 2015	This has been escalated through the Assistant Director and again restated through estates.
4	4.3 (m)	It is recommended that more staff are trained to enhance patients access to gym.	3	15 May 2015	An expression of interest has been circulated for staff that may be interested in this. The Trust, are linking with other Trusts to see if there is a more effective way of training staff.
5	4.3 (m)	Child and adolescent mental health service training is to be prioritised and issue reviewed.	3	15 May 2015	Key identified members of staff have already availed of these awareness sessions. Further sessions have been agreed and scheduled for

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No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
					every 6 months with the CAMHS team.
6	5.3.1 (c)	It is recommended that the ward's vulnerable adult procedures are reviewed and that the role of designated officer is not assigned to the ward manager.	2	15 May 2015	The procedures are being reviewed regionally and the trust will ensure that locally these guidelines are implemented. The recommendation regarding the role of the ward sister being assigned as a D.O. is being reviewed in line with this Regional Policy by the Safeguarding Lead. In the interim it has been recommended that the role of DO should not be allocated to the Ward Sister if the suspected abuse took place on that ward.
7	6.3.2 (b)	It is recommended that patient signatures are available on all relevant assessment and care documentation. Staff should record when a patient has refused or been unable to sign.	2	Immediate and ongoing	After every MDT meeting, the patients care plan is reviewed with the patient. The patient is offered an opportunity to sign the care plan. If they choose to decline, or they are unable, this is recorded. On the inspectors recommendation the ward has adopted a single sheet to evidence this, for each patient record. The Ward team are auditing patient care records to ensure this is done.
8	5.3.1 (a)	It is recommended that the ward manager ensures that patient	2	15 May	The mental health recovery care plan has been adopted and training has been requested to guide

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No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
		care plans are developed in response to individual assessed needs, person centred and comply with published guidance and standards.		2015	staff to ensure this is completed in keeping with published guidance and standards. Staff have been identified to form a development group to look at how the recovery plan reflects all the requirements under published guidance and standards
9	5.3.1 (c)	It is recommended that the Trust develops and implements a uniform policy for managing patient's finances within the Bluestone Unit.	2	15 May 2015	This policy is currently being reviewed by the finance directorate and will have been reviewed by 31st May 2015.
10	4.3 (m)	It is recommended that the ward manager ensures that all staff receive Human Rights, restrictive practice, capacity, consent and training on the Deprivation of Liberty safeguards.	1	31 July 2015	As highlighted during the inspection this training has been requested through the clinical education centre by the ward sister. This has been approved by the Assistant Director and the Trust has commissioned education days from the CEC on DoLs / Capacity care planning. These will take place over 4 days between 1 May and 7 July 2015.
11	5.3.1 (a)	It is recommended that the ward manager ensures that each patient has an individualised care	1	15 May 2015	As previously outlined in recommendation no8. All patients have a mental health recovery care plan.

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
		plan that reflects the rationale and assessment of any individual or blanket restrictions. The care plan should incorporate the Deprivation of Liberty Safeguards.			The unit has set up a group of staff to compliment the requested training as outlined in recommendation 10. This will enable them to share the learning and develop staffs ability to accurately document their practice. The Trust has commissioned education days from the CEC on DoLs / Capacity care planning. These will take place over 4 days between 1 May and 7 July 2015
12	5.3.1 (a)	It is recommended that the ward manager ensures that patients care plans reflect consideration of the Human Rights Act, particularly for those patients that are subject to any form of restrictive practice. Care plans should be person centred and incorporate the holistic and individualised needs of the patient.	1	15 May 2015	See recommendation response no 8, 10 11 and 12.
13	5.3.1 (a)	It is recommended that the ward manager ensures that all patients have a person centred discharge care plan that indicates the	1	15 May 2015	All patients will have a person centred discharge care plan. Discharge planning commences from the point of admission. This is also evidenced, through patients, medical and nursing notes. The

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
		actions to support and prepare patients for discharge.			mental health recovery care plan also assists in this process.
14	5.3.3 (b)	It is recommended that the ward manager ensures that patients previously unable to review their care plans are provided with an ongoing opportunity to review their care plans as their mental state improves; this should be recorded and/or signed by the patient.	1	Immediate and ongoing	Please see recommendation response no 7.
15	8.3 (j)	It is recommended that the ward manager ensures that staff assess patients consent to daily care and treatment, this should be recorded in the patients' individual care plans and continuous nursing notes.	1	Immediate and ongoing	As outlined in response no 10, training has been requested, regarding consent. The ward is exploring ways of recording this in a way which is meaningful. The unit will look to the training requested from Clinical education centre and the staff development group to help guide this.
16	5.3.1 (a)	It is recommended that the ward manager ensures that all patients' care plans are reviewed as prescribed. Reviews of care plans should ensure that care plans are measured and that the	1	Immediate and ongoing	With the introduction of the recovery care plan, It is a requirement that there is evidence of a review other than signature. Care plans are being audited to ensure that appropriate reviews are

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No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
		outcome of goals is assessed.			taking place.
17	5.3.3 (b)	It is recommended that the ward manager ensures that risk screening tools are completed in full. If a decision is made not to proceed to a full comprehensive risk assessment then a clear rationale must be recorded and signed by all relevant parties, as outlined in the Promoting Quality Care Guidance Document – Good Practice on the Assessment and Management of Risk in Mental Health and Learning Disability Services- May 2010.	1	Immediate and ongoing	Risk assessments are reviewed weekly at the MDT meeting. This has been included as one of the items audited in the MDT notes.
18	4.3 (i)	It is recommended that the Trust urgently review the continued use of profiling beds on the ward. The outcome of the review should be clearly reflected in the environmental and ligature risk assessment. Patients who continue to use profiling beds	1	15 May 2015	In response to the regional guidance on profile beds we undertook an assessment of the need for profile beds in which we concluded that there was good reasons to maintain at least one profile bed in each room dedicated to accommodate people who are less able. There are people with a combination of physical and mental health needs, and in order

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No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
		should have a clear rationale in their care file supported by a risk assessment and care plan.			not to discriminate against these individuals, the Trust has taken the decision to retain some profiling beds on the ward to ensure these needs are met. It is recognise that carries with it a risk and this has been assessed and control measures in place and it is on the Risk register for the ward. On admission anyone who is being cared for in a room with a profiling bed will have the risks associated with this recorded in their risk assessment and any management of that risk clearly recorded and communicated through that. Changes to risk are reviewed at least weekly at the MDT meeting and plans adjusted accordingly.
19	7.3 (h)	It is recommended that the Trust urgently review the safe storage of fire extinguishers on the ward so to ensure easy access to firefighting equipment whilst maintaining staff and patient safety.	1	15 May 2015	A managed solution using existing cupboard space has been proposed by the fire officer and he is making that recommendation to the estates department.
20	5.3.1 (f)	It is recommended that the estates department address the	1	31 July	There has been ongoing investigation into this. It would appear that recent intervention has resolved

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No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
		pungent smell throughout the ward particularly in the Occupational Therapy room.		2015	this.
21	5.3.1 (f)	It is recommended that the estates department repair or replace the flooring in areas where the vinyl is 'bubbling'.	1	31 July 2015	This has been escalated to the Assistant Director and restated again through estates.
22	5.3.1 (c)	It is recommended that the Trust ensures that all Policies and Procedures associated with the ward are available to staff for reference, guidance and support.	1	31 July 2015	All policies and procedures are now available to all ward staff in hard copy and / or accessible on the Trust intranet.

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	Angeline Magennis
NAME OF CHIEF EXECUTIVE / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Micéal Crilly

Inspector assessment of returned QIP				**Inspector**	**Date**
		Yes	**No**		
A.	Quality Improvement Plan response assessed by inspector as acceptable	x		Kieran McCormick	**08/04/15**
B.	Further information requested from provider		x	Kieran McCormick	**08/04/15**