The Regulation and Quality Improvement Authority

Silverwood, Bluestone Unit

Craigavon Area Hospital

Southern Health and Social Care Trust

Unannounced Inspection Report

Date of inspection: 27 August 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.

Contents

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 Purpose and Aim of this Inspection

To review the ward's progress in relation to recommendations made following previous inspections.

To review the ward's progress in relation to recommendations made following a serious adverse incident.

To meet with patients to discuss their views about their care, treatment and experiences.

To assess that the ward physical environment is fit for purpose and delivers a relaxed, comfortable, safe and predictable environment.

To evaluate the type and quality of communication, interaction and care practice during a direct observation using a Quality of interaction Schedule (QUIS).

2.1 What happens on inspection

What did the inspectors do:

- reviewed the quality improvement plan sent to RQIA by the Trust following the last inspection
- talked to patients, carers and staff
- observed staff practice on the days of the inspection
- looked at different types of documentation

At the end of the inspection the inspectors:

- 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 any necessary improvements

3.0 About the ward

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 15 patients on the ward on the day of the inspection and three 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 and occupational therapy. Patients on the ward have access to an independent advocacy service.

4.0 Summary

Progress in implementing the recommendations made following the previous inspection carried out on 9 and 10 February 2015 were assessed during this inspection. There were a total of 22 recommendations made following the last inspection.

It was good to note that 18 recommendations had been implemented in full.

One recommendation had been partially met and three recommendations had not been met. Two of these recommendations will be restated for a fourth time, one for a third time and another for a second time following this inspection.

On the day of the inspection the inspectors evidenced the ward to be relaxed, clean and the atmosphere was welcoming. Patients were at ease in their surroundings and noted to be moving freely throughout the ward. Staff maintained a continued presence in the main ward areas and patient/staff interactions were observed as supportive and positive.

The ward's environment was well aired and fresh smelling. The dining area was maintained to a good standard and inviting. Information regarding the ward's multi-disciplinary team, including the doctor on duty, was not displayed.

Four sets of patient care documentation reviewed by the inspectors evidenced that patients' signatures were recorded on care documentation. If patients were unable or refused to sign this was also recorded. Patients' care plans were individualised, person centred and regularly reviewed. Patients' care records reflected consideration of the Human Rights Act. There was evidence that staff continually assessed patients' consent to care and treatment. Patients care files reviewed had an individualised discharge care plan in place.

Patients who met with the inspectors reported that they felt safe on the ward and had no concerns in their ability to speak with nursing staff as required.

Staff who met with the inspectors expressed no concerns in relation to the care and treatment of patients on Silverwood. Staff reflected positively on the care and treatment provided to patients.

The acting ward manager was the person in charge of the ward on the day of inspection.

4.1 Implementation of Recommendations

Nine recommendations which relate to the key question "**Is Care Safe**?" were made following the inspection undertaken on 9 and 10 February 2015.

These recommendations concerned the updating and availability of policies and procedures, person centred care planning, accurate completion of risk assessments, use of profiling beds, fire safety and replacement of the ward flooring.

The inspectors noted that eight recommendations had been fully implemented:

- Identified policies and procedures had been updated.
- Patients care plans were person centred.
- Risk assessments were in place for each patient and regularly reviewed.
- Firefighting equipment was available on the main ward area.
- Arrangements were in place for replacing the ward floor.

However, despite assurances from the Trust, one recommendation had not been fully implemented. This included concerns identified regarding ward managers continuing to fulfil the role of designated officer for the purpose of safeguarding vulnerable adult investigations.

Four recommendations which relate to the key question "**Is Care Effective**?" were made following the inspection undertaken on 9 and 10 February 2015.

These recommendations concerned the provision of child and adolescent mental health training for staff, care plans to reflect patients deprivation of liberty/discharge planning and the review of patients' care plans.

The inspectors noted that three recommendations had been fully implemented:

- Child and adolescent mental health training had been provided for staff.
- Patients had a person centred discharge care plans.
- Patients' care plans were regularly reviewed.

However, despite assurances from the Trust, one recommendation had not been fully implemented. The inspectors reviewed the care files for four patients and noted that patients detained in accordance with the mental health order had an individualised deprivation of liberty safeguards care plan in place. However for one of the four patients subject to detention the care plan did not provide a rationale as to the reasons for the deprivation that was in place. The inspectors were also concerned that these care plans were not on the PARIS system in line with all other recovery care plans.

Nine recommendations which relate to the key question "**Is Care Compassionate**?" were made following the inspection undertaken on 9 and 10 February 2015.

These recommendations concerned repainting of the ward, installation of ventilation in the quiet room, patient access to the gym, patient signatures on their care documentation, staff training, care plans in relation to restrictive practices, assessing and documenting patients' consent to care and treatment and the pungent smell on the ward.

The inspectors noted that seven recommendations had been fully implemented:

- Arrangements were in place for patients to use the gym.
- Patients had the opportunity to sign their care plans.
- Staff had received up to date training.
- Patients' care plans were person centred.
- Staff were assessing and recording patients' consent to care and treatment.
- The pungent smell on the ward had been resolved.

However, despite assurances from the Trust, two recommendations had not been fully implemented. The ward had not been repainted and ventilation had not been resolved in the quiet room.

4.2 Serious Adverse Incident Investigation

A serious adverse incident (SAI) occurred relating to this ward on 20 February 2014. The inspectors reviewed the Trust's progress in addressing recommendations made related to ward practices following the Trust's investigation of the SAI. All three recommendations were assessed as part of the inspection.

These recommendations concerned recording the referral to mental health services at time of discharge from an acute ward. Obtaining the patients expected date of discharge to allow prompt follow up with the ward by the home treatment crisis response (HTCR) team on the predicted day of discharge. The dissemination of information to staff on the immediate risk post discharge of patients where there are risks of self-harm and/or patients whose mental health has been an influencing factor in their admission to an acute ward.

The inspectors noted that progress had been made in the implementation of each of the recommendations as a result of the SAI and the inspectors had no further concerns to add.

5.0 Ward Environment

"A physical environment that is fit for purpose delivering a relaxed, comfortable, safe and predictable environment is essential to patient recovery and can be fostered through physical surroundings." Do the right thing: How to judge a good ward. (Ten standards for adult-in-patient mental health care RCPSYCH June 2011)

The inspectors assessed the ward's physical environment using a ward observational tool and check list.

Summary

The ward had an information / welcome pack available for patients. There was information about the wards performance. Patients had placed compliments about their experience on a 'recovery tree'. Art work completed by patients was displayed throughout the ward that also described their experience of mental health.

On the day of the inspection there was enough staff to assist and support patients with their daily activities of living and recreational activities.
The ward was clean, tidy and clutter free, odours were neutral. However there were areas of the ward that required painting and some flooring required

replacing. Ventilation was good throughout the ward with the exception of a quiet room. Inspectors were informed this room was prone to overheating. Recommendations in relation to these environmental issues have been restated for a third time.

Bedrooms were single with en-suite facilities. A visitor's room was available; patients could also receive visitors on the ward. Furnishings were clean and comfortable. Patients could access a telephone in private. Signage around the ward was clear and enabled patients to orientate themselves around the ward.

Patients can request staff to lock their door when they have exited the room. Patients had access to an outside space. The medical room was well maintained.

There were quiet areas for patients to retreat to. Seating around the ward promoted social interaction between patients and staff. There were no areas prone to overcrowding.

Fresh water was available. The dining area was clean and comfortable. There was a range of information displayed in the patients' communal areas this included how to make a complaint; advocacy services; the right to access information held about the patients; the ward activity schedule; the date of patients' forum meetings and; the day of the ward round; each patients' primary nurse and what staff were allocated to each patient on the day for one to one time.

Confidential information was stored appropriately and staff telephone conversations could not be overheard.

There were three profiling beds on the ward. The ward had an up to date ligature risk assessment completed. Risk assessments and care plans were completed for patients using the profiling beds.

Inspectors identified other areas which should be reviewed by the ward manager to improve standards on the ward in accordance with good practice guidance. These include;

- Information in relation to the controlled access from the ward should be included in the ward information book;

- Displaying information about who was on duty; the ward doctor; information about the multi-disciplinary team;

The detailed findings from the ward environment observation are included in Appendix 3.

6.0 Observation Session

Effective and therapeutic communication and behaviour is a vitally important component of dignified care. The Quality of Interaction Schedule (QUIS) is a method of systematically observing and recording interactions whilst remaining a non- participant. It aims to help evaluate the type of communication and the quality of communication that takes place on the ward between patients, staff, and visitors.

The inspectors completed a direct observation using the QUIS tool during the inspection and assessed whether the quality of the interaction and communication was positive, basic, neutral, or negative.

Positive social (PS) - care and interaction over and beyond the basic care task demonstrating patient centred empathy, support, explanation and socialisation

Basic Care (BC) – care task carried out adequately but without elements of psychological support. It is the conversation necessary to get the job done.

Neutral – brief indifferent interactions

Negative – communication which is disregarding the patient's dignity and respect.

Summary

On the day of the inspection the inspectors observed interactions between staff and patients. Eight interactions were noted in this time period. The outcomes of these interactions were as follows;

Positive	Basic	Neutral	Negative
100%	0%	0%	0%

All interactions were observed as positive. Staff were kind and compassionate and treated patients with dignity and respect. Staff were also empathetic when communicating with the patients. Staff were observed to be actively engaging with patients and encouraged patients to participate in activities. Staff were observed supporting a patient who did not speak English. Staff had purchased a goldfish for the ward. The patient was observed caring for the fish and staff used these times as a means of engagement with the patient. An interpreter visits the ward to support the patient with their communication needs. Staff encouraged patients to participate in activities.

The detailed findings from the observation session are included in Appendix 2.

7.0 Patient Experience Interviews

A total of five patients met with the lay assessor and inspectors on the day of the inspection.

Three patients agreed to meet with the lay assessor to talk about their care, treatment and their experience of the ward. Two of which agreed to complete a questionnaire with the lay assessor.

Two patients agreed to complete a questionnaire with the inspectors. On these occasions it was more appropriate to use an easy to read questionnaire. An interpreter was present during one of the interviews.

Overall the majority of responses indicated that patients felt safe on the ward. Patients knew how to make a complaint and the role and function of advocacy services. However, two patients stated that, although they had been informed of their rights they had not been given enough time to understand them.

In relation to effective care. Four out the five patients interviewed stated they were fully involved in their care and treatment plans. One patient stated they weren't sure, however the doctor explains their treatment. Four patients stated staff tell them how they are progressing. Two patients stated they were offered the opportunity to attend activities every day. Two patients stated they hadn't been offered the opportunity and one patient did not answer. Inspectors noted a range of activities were displayed and observed patients participation. The occupational therapist was off duty on the day of the inspection. An activity room was available for patients. Three patients indicated that being on the ward has helped with their recovery. Two patients did not answer.

All responses to the questions asked indicated that patients felt that care was compassionate. Patients felt staff listen to them, seeked permission before care delivery and patients stated they were treated with dignity and respect.

The detailed findings are included in Appendices 4 and 5.

8.0 Other areas examined

During the course of the inspection the inspectors met with:

Ward Staff	**2**
Other ward professionals	**2**
Advocates	**0**

Ward staff

The inspectors spoke with two members of nursing staff working on the day of inspection. Staff who met with the inspectors did not express any concerns regarding the ward or patients' care and treatment.

Other ward professionals

The inspectors met with a visiting interpreter during the course of the inspection. The consultant psychiatrist attended the inspection feedback. The inspectors spoke at length with the consultant psychiatrist in relation to a number of the recommendations. Neither professional expressed any concerns regarding the ward or patients' care and treatment.

Advocate

The inspection was unannounced. No advocates were available to meet with the inspectors during the inspection.

9.0 Next Steps

A Quality Improvement Plan (QIP) which details the areas identified for improvement has been sent to the ward. The Trust, in conjunction with ward staff, must complete the QIP detailing the actions to be taken to address the areas identified and return the QIP to RQIA by 22 October 2015.

The lead inspector will review the QIP. When the lead inspector is satisfied with actions detailed in the QIP it will be published alongside the inspection report on the RQIA website.

The progress made by the ward in implementing the agreed actions will be evaluated at a future inspection.

Appendix 1 – Follow up on Previous Recommendations

Appendix 2 – QUIS
This document can be made available on request

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

Appendix 4 – Patient Experience Interview
This document can be made available on request

Appendix 5 – Patient Experience Interview (Lay Assessor)
This document can be made available on request

Appendix 1

Follow-up on recommendations made following the announced inspection on 9 and 10 February 2015

No.	Reference.	Recommendations	Number of times stated	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	5.3.1 (c)	It is recommended that there is a timeline for updating policies and procedures.	3	The inspectors were aware following a previous inspection in the Bluestone Unit that the following policies and procedures had been reviewed: • Continuous Observations • Search Policy • Admission & Discharge • Child Visiting • Bed Management Protocol • Procedure for Locked Doors • Procedures for Patients Private Property The inspectors were provided with evidence that the safeguarding vulnerable adult procedures are currently under review as a result of the new regional policy. An implementation work stream has convened to consider the implication of the new policy and any associated procedures.	Met
2	5.3.1 (f)	The ward requires repainting.	3	The inspectors completed an observation of the ward and noted that the ward had not been repainted. The inspectors again noted a number of communal areas and patients' bedrooms that required urgent attention. The inspectors were informed that the painting of the ward had been approved at directorate level however further approval was outstanding from the chief executive's office. The inspectors were not provided with any	Not met

				date of commencement or completion of the work despite ongoing pursuance from the acting ward manager as recent as 19 August 2015. This recommendation will be restated for a **fourth** time.	
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	The ventilation in the sitting/quiet room had not been resolved. The acting ward manager advised that the heat in the room remains an issue on warm days. The inspectors were not provided with any date of commencement or completion of the work despite ongoing pursuance from the acting ward manager as recent as 19 August 2015. This recommendation will be restated for a **fourth** time.	Not met
4	4.3 (m)	It is recommended that more staff are trained to enhance patients access to gym.	3	The inspectors reviewed records for the ward that evidenced one member of staff who is currently trained to facilitate patient access to the gym. This member of staff is provided with protected time for this. The inspectors reviewed the gym log records for the ward and noted that patients were routinely offered access to the gym throughout the week. Despite this the uptake in gym usage was poor, the ward retains records of each occasion patients are offered access to the gym and their response. The inspectors also reviewed evidence of senior	Met

				hospital management recently liaising with colleagues in other trusts in order to gather suggestions to improve access to the gym and number of staff trained to facilitate gym usage.	
5	4.3 (m)	Child and adolescent mental health service training is to be prioritised and issue reviewed.	3	The inspectors reviewed the training records for the ward and noted that out of the 24 staff currently working on the ward 13 staff had attended CAMHS awareness training. Further training was booked for October 2015 for the remaining staff.	Met
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	The inspectors were advised that the current acting ward manager does not fulfil the role of designated officer for Silverwood ward. Despite this the inspectors were advised that ordinarily the process of ward managers carrying out the role of designated officer remains unchanged. The inspectors reviewed recent concerns expressed collectively in writing from ward managers in the Bluestone Unit to senior hospital management in relation to carrying out this function. RQIA remains concerned that this recommendation is unresolved and remains outstanding. The inspectors were provided with evidence that the safeguarding vulnerable adult procedures are currently under review as a result of the new regional policy. An implementation work stream has convened to consider the implication of the new policy and any associated procedures. This recommendation will be restated for a **third**	Not met

				time.	
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	The inspectors reviewed four patients care files and noted that in each case patients had regularly signed or had been offered the opportunity to sign their care plan, if refused this was recorded. One patient who lacked capacity had arrangements in place in relation to their care plans.	Met
8	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.	2	The inspectors reviewed four patients care files and noted that in each case care plans were individualised and person centred. The inspectors noted in one case the recovery care plan did not reference the needs of an individual's physical nursing needs and as such a new recommendation will be made in relation to this.	Met
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	The inspectors reviewed the policy and procedure for managing patients' private property this was issued in May 2015.	Met
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	The inspectors reviewed the staff training records for the ward and noted that all registered nurses had received this training. Training had not been provided to health care assistant staff however the acting ward manager advised that this was under review with a view to staff already trained sharing their knowledge at local level to colleagues.	Met

11	5.3.1 (a)	It is recommended that the ward manager ensures that each patient has an individualised care plan that reflects the rationale and assessment of any individual or blanket restrictions. The care plan should incorporate the Deprivation of Liberty Safeguards.	1	The inspectors reviewed the care files for four patients and noted that patients detained in accordance with the mental health order had an individualised deprivation of liberty safeguard care plan in place. However for one of the four patients subject to detention the care plan did not provide a rationale as to the reasons for the deprivation that was in place. Patients not detained had a core generic deprivation of liberty care plan in place with reference to the locked door environment. The care plans however did not identify that voluntary patients could leave the ward at any time. The inspectors were also concerned that these care plans were not on the PARIS system in line with all other recovery care plans. This recommendation will be restated for a second time and a new recommendation will be made in relation to ensuring all care plans are documented on the PARIS system.	Partially met
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	1	The inspector reviewed the care files for four patients and noted that in each case patients' care plans made frequent reference to the respective articles of the human rights legislation. Recovery care plans in each case were person centred and incorporated the holistic needs of each patient.	Met

		incorporate the holistic and individualised needs of the patient.			
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 actions to support and prepare patients for discharge.	1	The inspectors reviewed the care files for four patients and noted that in the case of two patients who no longer required treatment a person centred discharge care plan was in place. For the other two patients care plans were not in place as they were not currently fit for discharge.	Met
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	The inspectors reviewed the care files for four patients and noted that in each case patients had regularly signed or had been offered the opportunity to sign their care plan throughout the month, if refused this was recorded. One patient who lacked capacity had arrangements in place in relation to their care plans.	Met
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	The inspectors reviewed the care files for four patients and noted that consent had been evidenced in each case throughout the individual patient's respective care plans. Further evidence was also included in patient's daily nursing progress notes.	Met

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 outcome of goals is assessed.	1	All Mental Health and Recovery care plans with the exception of care plans in relation to the risk of self-harm using a profiling bed and restrictive practices were documented on the electronic care recording system (PARIS). Inspectors reviewed the electronic and paper copies of care plans in relation to four patients. Inspectors noted that all of the electronic copies of patient care plans had been reviewed each week at the multi-disciplinary team meeting, and were updated as required following the meeting. However the paper copies of care plans in relation to self-harm using profiling beds and restrictive practices had not been updated weekly. A new recommendation has been made in relation to ensuring all care plans are documented on the PARIS system.	Met
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	1	The inspectors reviewed the promoting quality care documentation for four patients and noted in the case of each patient a risk screening tool had been completed. An associated comprehensive risk assessment was also subsequently completed. In each case these had been appropriately completed, regularly reviewed and updated.	Met

		Practice on the Assessment and Management of Risk in Mental Health and Learning Disability Services- May 2010.			
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 should have a clear rationale in their care file supported by a risk assessment and care plan.	1	The inspectors were advised by the acting ward manager that three profiling beds remain on the ward. The acting ward manager provided a summary of the process in place for risk assessing and care planning for those patients with or without a clinical need who use a profiling bed. The inspectors also noted that the continued use of profiling beds was clearly reflected in the ward environmental and ligature risk assessments. The inspector reviewed the use of the profiling bed for a patient with a clinical need. The patient's care file provided a clear rationale for the use of the bed. A supporting care plan and risk assessment were in place and regularly reviewed.	Met
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	Fire extinguishers are now available behind locked doors on the main ward area following approval from the trust fire officer. All staff carry a key for access to the locked cupboards. A spare key is also available in the main nurses' station.	Met

20	5.3.1 (f)	It is recommended that the estates department address the pungent smell throughout the ward particularly in the Occupational Therapy room.	1	The inspectors completed an observation of the entire ward and noted that the pungent smell was now gone. The acting ward manager confirmed that this matter had been resolved by estates with no further concerns.	Met
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	The inspectors completed a tour of the ward and noted that 'bubbling' of the vinyl flooring remains an issue in areas throughout the ward. Despite this the inspectors reviewed recent email evidence of new flooring having been chosen with further correspondence advising that completion of the work will be in the imminent future.	Met
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	A policies and procedures folder has now been implemented with all current policies and procedures accessible to all staff. The acting ward manager also advised that all staff have access to policies and procedures on the trust intranet. Daily handover sheets also advise staff on the location of policies and procedures and any new updates.	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 – 29701	For patients requiring onward referral to mental health services at time of discharge from an acute ward, this should be clearly noted within the discharge checklist of the patients chart, including how and when to make this referral.	The inspectors reviewed the discharge request form and discharge checklist which evidenced a section available to remind staff to complete community mental health team referrals where relevant.
2	SAI – 29701	For patients requiring HTCR input at time of discharge, the mental health services team should obtain the patients expected date of discharge to allow prompt follow up with the ward by the HTCR team on the predicted day of discharge.	The ward has an inpatient crisis response member of staff who will assist in assessing patients prior to their discharge. This assessment which is ward based helps to determine the patients discharge, the member of staff will then liaise and co-ordinate with the key worker to organise the discharge. If no key worker is identified the home treatment crisis response team will still accept the patient for discharge and manage the patients care in the community.
3	SAI – 29701	Ward managers should be given information for dissemination to ward staff on the immediate risk post discharge of patients where there are risks of self-harm and/or patients whose mental health has been an influencing factor in their admission to an acute ward, and how this makes the timely referral to mental health services essential.	The acting ward manager discussed the processes in place for the discharge of patients. The acting ward manager advised that these processes are communicated to all staff on their induction and staff would be familiar with processes as part of the frequent discharge of patients.

Quality Improvement Plan

Unannounced Patient Experience Interview Inspection

Silverwood, Bluestone Unit, Craigavon Area Hospital

27 August 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 acting ward manager, the consultant psychiatrist and the patient flow and bed management co-ordinator 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
Is Care Safe?					
1	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.	3	30 November 2015	During the implementing the new Regional Safeguarding policy, the Ward manager will be required to retain the role of Designated Officer. In the interim a duty rotation of ward sisters allocated to the Designated Officer role is in place where a Ward Sister will not be the Designated Officer for a PVA in her own ward.
2	5.3.1 (a)	It is recommended that the ward manager ensures that patients' support and recovery care plans reflect any associated physical health care needs and the level of care/support required.	1	Immediate and ongoing	All patients care plans reflect the level of support/assistance/prompting they require with their personal care which is recorded in the 'physical section' of the Mental Health Recovery Care Plan. The ward manager will ensure this is completed by doing weekly audit on all care plans.
Is Care Effective?					
3	5.3.1 (a)	It is recommended that the ward manager ensures that each	2	Immediate and	Each patient has an Individualised care plans which is in place on the PARIS system. Staff

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
Is Care Safe?					
		patient has an individualised care plan that reflects the rationale and assessment of any individual or blanket restrictions. The care plan should incorporate the Deprivation of Liberty Safeguards.		ongoing	education around Care Planning for restrictive practices and deprivation of liberty has taken place with the Clinical Education Centre. and ward champions to produce care plans in line with RQIA recommendations and appropriate referencing of the Human Rights Act. Any patient experiencing restrictions required to be in place for the safe care of patients in hospital will have this reflected in their care plan under 'other' section with a rationale for the restriction and Deprivation of Liberty safeguards reflected. Care plans are audited on weekly basis to monitor compliance and correct omissions .
4	5.3.1 (f)	It is recommended that the ward manager ensures that all care plans are centralised onto the PARIS electronic recording system.	1	31 October 2015	As part of the ongoing implementation of the PARIS patient record work continues to transfer records previously recorded on paper. All care plans are recorded on the electronic care record system - PARIS

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
Is Care Safe?					
Is Care Compassionate?					
5	5.3.1 (f)	The ward requires repainting.	4	31 December 2015	Confirmation from Estates has been received and states that all minor works which includes painting will be completed within this financial year. The Head of Service has met with Estates Design Team to agree the operationalization of this programme of work with timeframes.
6	5.3.1 (f)	It is recommended that the ventilation in the sitting room/quiet room is monitored by the estates department and rectified.	4	31 December 2015	As above recommendation. Ventilation is included in minor works.
7	6.3.2 (b)	It is recommended that the Trust update the ward information booklet/pack to reflect all blanket and potential individual restrictions that patients may experience whilst on Silverwood	1	31 October 2015	The Trust has drafted changes to update the ward information booklet to reflect blanket restrictions that a patient may experience whilst a patient in Silverwood Ward.

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
Is Care Safe?					
		ward.			
8	5.3.1 (f)	It is recommended that the Trust review the arrangements for the maintenance of the outside garden/smoke area to ensure that the area is regularly visited and maintained by estates or support services.	1	31 October 2015	The Head of Service has requested that Estates review their contract for cleaning garden/courtyard areas as a matter of urgency.

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	Sinead Davidson
NAME OF CHIEF EXECUTIVE / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Francis Rice

Inspector assessment of returned QIP				**Inspector**	**Date**
		Yes	**No**		
A.	Quality Improvement Plan response assessed by inspector as acceptable	x		Alan Guthrie	19 November 2015
B.	Further information requested from provider				