RQIA

Mental Health and Learning Disability

Unannounced Inspection

Willow Ward, Craigavon Area Hospital

Southern Health and Social Care Trust

19 & 20 March 2015

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1.0 General Information

Ward Name	Willow
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	Mary Donnelly
Email address	marym.donnelly@southerntrust.hscni.net
Person in charge on day of inspection	Mary Donnelly
Category of Care	Acute Mental Health for patients over 65 years
Date of last inspection and inspection type	9 & 10 July 2012
Name of inspector	Audrey McLellan

2.0 Ward profile

Willow is an acute mental health admission ward which provides assessment and treatment for patients over 65 years and accommodates five beds for patients 50- 64 years. The ward is situated within the Bluestone site located in Craigavon Area Hospital. The ward has 20 beds and provides a service for the Southern Health and Social Care Trust.

The ward is located on a single floor with a reception area, and a visitor room at the entrance to the ward. All patients have a single room with ensuite facilities. The nursing station is centrally positioned. Patients have access to an enclosed garden area with adequate seating and a sheltered smoking area. The garden area also has a vegetable plot and flower beds.

There are three small sitting areas within the ward with books and games available for patients. An Occupational Therapy (OT) activity room is also available for patients and a programme of daily activities is displayed on the door to this room.

The multidisciplinary team consists of three consultant psychiatrists (one for each area covered by the ward Armagh/Dungannon, Craigavon/Banbridge

and Newry/Mourne), nurses, health care workers, an occupational therapist, a technical instructor and a pharmacist.

At the time of the inspector there were 16 patients on the ward and four patients were detained in accordance with the Mental Health (Northern Ireland) Order 1986. There were no patients on leave.

3.0 Introduction

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of Northern Ireland's health and social care services. RQIA was established under the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, to drive improvements for everyone using health and social care services. Additionally, RQIA is designated as one of the four Northern Ireland bodies that form part of the UK's National Preventive Mechanism (NPM). RQIA undertake a programme of regular visits to places of detention in order to prevent torture and other cruel, inhuman or degrading treatment or punishment, upholding the organisation's commitment to the United Nations Optional Protocol to the Convention Against Torture (OPCAT).

3.1 Purpose and Aim of the Inspection

The purpose of the inspection was to ensure that the service was compliant with relevant legislation, minimum standards and good practice indicators and to consider whether the service provided was in accordance with the patients' assessed needs and preferences. This was achieved through a process of analysis and evaluation of available evidence.

The aim of the inspection was to examine the policies, procedures, practices and monitoring arrangements for the provision of care and treatment, and to determine the ward's compliance with the following:

- The Mental Health (Northern Ireland) Order 1986;
- The Quality Standards for Health & Social Care: Supporting Good Governance and Best Practice in the HPSS, 2006
- The Human Rights Act 1998;
- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003;
- Optional Protocol to the Convention Against Torture (OPCAT) 2002.

Other published standards which guide best practice may also be referenced during the inspection process.

3.2 Methodology

RQIA has developed an approach which uses self-assessment, a critical tool for learning, as a method for preliminary assessment of achievement of the inspection standards.

Prior to the inspection RQIA forwarded the associated inspection documentation to the Trust, which allowed the ward the opportunity to demonstrate its ability to deliver a service against best practice indicators. This included the assessment of the Trust's performance against an RQIA Compliance Scale, as outlined in Section 6.

The inspection process has three key parts; self-assessment, pre-inspection analysis and the visit undertaken by the inspector. Specific methods/processes used in this inspection include the following:

- analysis of pre-inspection information;
- discussion with patients and/or representatives;
- discussion with multi-disciplinary staff and managers;
- examination of records;
- consultation with stakeholders;
- file audit; and
- evaluation and feedback.

Any other information received by RQIA about this service and the service delivery has also been considered by the inspector in preparing for this inspection.

The recommendations made during previous inspections were also assessed during this inspection to determine the Trust's progress towards compliance. A summary of these findings are included in section 4.0, and full details of these findings are included in Appendix 1.

An overall summary of the ward's performance against the human rights theme of Autonomy is in Section 5.0 and full details of the inspection findings are included in Appendix 2.

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

4.0 Review of action plans/progress

An unannounced inspection of Willow ward was undertaken on 19 & 20 March 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 9 & 10 July 2012 were evaluated. The inspector was pleased to note that 12 recommendations had been fully met and compliance had been achieved in the following areas:

- When patients are not able to avail of written information about the detention process this was recorded
- Patients are given a choice to attend the multidisciplinary team meetings.
- Information about patients' physical status is clarified in the patients' care documentation
- A programme of planned upgrading of refurbishment works (painting) has commenced.
- All staff had formal supervision meetings and appraisal in accordance with policies and procedures.
- The ward manager had reviewed the format of formally recorded staff supervision and the opportunity for individual supervision sessions had increased
- The ward manager had reviewed training records to identify any gaps in training and a plan had been devised to address deficits in training.
- All incidents of restraint were recorded in accordance to regional and Trust policy.
- A system to provide the ward manager with information in relation to review and outcomes of accidents, incidents and near misses that may influence ward practices was in place.
- Information in relation to the locked environment was made available to patients and visitors.
- A new ward information booklet had been developed and the font size of the print had been increased
- Social work arrangements for the ward ensured that patients were not disadvantaged by the absence of a dedicated ward social worker

However, despite assurances from the Trust, four recommendations had not been met. Two recommendations will require to be restated for a second time and two recommendations will be restated for a third 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

There were no recommendations made following the patient experience interview inspection on 9 October 2014.

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

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

- Items brought into the ward on admission are listed appropriately, the area of their storage or transfer recorded, and appropriate receipting undertaken.
- Appropriate systems are in place to record purchases made by staff on behalf of patients with related receipts.

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

Details of the above findings are included in Appendix 1.

5.0 Inspection Summary

Since the last inspection a new ward information booklet had been developed and the font size of the print had been increased. A programme of planned upgrading of refurbishment works (painting) had commenced and plans were in place for the patients' rooms to be painted. Patients are now given a choice to attend their multidisciplinary team meetings.

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 three set of care records. There was evidence in patients' progress notes to indicate that patients' capacity to consent to care and treatment was monitored and re-evaluated throughout their admission. However the records did not indicate what specific area of capacity had been assessed and the outcome. A recommendation has been made in relation to this.

The inspector discussed one patient's capacity in relation to their ability to understand their care and treatment with the ward manager as it was unclear in the care records. The ward manager informed the inspector that the patient had been assessed as not having capacity to consent to care and treatment. However this was not recorded in the patient's care records and there was no

evidence that a best interest decision making care pathway had been followed even though the patient had not agreed to the restrictive practice care plan that was in place. There was also no record of any multi-disciplinary best interest decisions in relation to the patient's discharge plans or future accommodation needs. There was no evidence of family involvement. A recommendation has been made in relation to this.

The multidisciplinary template evidenced that patients' views had been sought prior to the multidisciplinary meetings. However these records were inconsistently signed therefore there were occasions when there was no record to indicate if patients had attended the meeting or if they had refused to attend. A recommendation has been made in relation to this.

The inspector spoke to two staff nurses who both demonstrated an understanding of the importance of capacity and gaining consent.

Consideration of patients' Human Rights Article 8 to respect for private and family life and Article14, right to be free from discrimination was evidenced through the wards arrangements for patients to see their relatives/carers outside of the set visiting times. The inspector noted that visiting hours were flexible to accommodate some visitors who had to travel long distances to see their relatives. The inspector spoke to two relatives who both advised that the staff were very approachable on the ward and are accommodating with regard to visiting times. There was evidence in the patients' care records of patients', relatives/carers been updated when appropriate on patients' care and treatment.

There was evidenced in three sets of care records that patients had up to date assessments in place. Comprehensive risk assessments had been completed for all three patients and there was evidence that these were reviewed at the weekly multidisciplinary team meetings.

It was good to note that care plans were person centred, individualised and in accordance to the assessed needs of each patient. Core care plans were in place in relation to patients who had been detained in accordance with the Mental Health (Northern Ireland) Order 1986. Care plans in the three sets of care records had been reviewed regularly and signed by patients and if they were not signed the reason for this was recorded. However in two sets of care records there was evidence that care plans had not been reviewed appropriately. Recommendations made at the multidisciplinary team meetings and from updated assessments had not been included in the care plans even though they had been reviewed and signed by nursing staff.

In two sets of care records reviewed there was evidence in the 'weekly ward team meeting' template that these patients did not have capacity to understand their care and treatment. However, there were no care plans in place to indicate how this was being managed on the ward. A recommendation has been made in relation to this

Progress notes by the nursing staff indicated ongoing evaluation of the patient's care, in relation to each individual care plan. However the progress records in one set of care records for a patient who had been on the ward for a long period did not include a detailed account of the patient's progress in relation to each care plan in place. Each daily record appeared to record the same information with no evidence of evaluation of care plans. A recommendation has been made in relation to this.

Patients' communication needs were addressed during patients' initial assessment. Staff who met with the inspector advised that if concerns are raised regarding patients' communication needs a referral can be made to the Trust's interpreting service.

The inspector was informed that all the beds on the ward were profiling beds. The inspector was concerned to note that patients were being nursed in profiling beds without an individualised risk assessment in place. A recommendation has been made in relation to this.

An Occupational Therapist (OT) worked 18 ½ hours on the ward completing functional assessments and attending multidisciplinary ward meetings three times a week. The ward also had a technical instructor (TI) who worked 18 hours on the ward (6 hours on Tuesday, Wednesday and Thursday) setting up therapeutic activities. The inspector met with the OT team leader who advised that the OT meets with the TI twice a week to gain an update on patients' progress so that they can report this to the multidisciplinary team at the weekly ward meeting. However, there were no records in all three sets of care documentation of patients' progress or participation in therapeutic activities completed by the TI. A recommendation has been made in relation to this.

In the care records reviewed there was evidence in two sets of records that functional assessments had been completed. There was evidence that the OT had made links with patients' carers/relatives to update them on the patients' progress in relation to these assessments.

Records in the weekly ward team meeting template indicated that one patient had 'declined all OT therapy'. However there were no records in the patient's progress notes to indicate if this patient had been encouraged to attend activities or why there was no assessments completed by the Occupational Therapist. There was no record to state if the patient had declined to have an OT assessment completed and therefore activities had not been set up which they liked to participate in. A recommendation has been made in relation to this.

There were no individualised recovery focused therapeutic/recreational care plans completed to address patients' assessed needs. A recommendation has been made in relation to this.

The inspector was advised that patients cannot be referred for psychological interventions whilst on the ward as there is no psychologist attached to the multidisciplinary team. A recommendation has been made in relation this

There were four patients detained on the ward in accordance with the Mental Health (Northern Ireland) Order 1986. The inspector reviewed two sets of care documentation, whereby the patients had been detained and there was evidence that these patients had been informed of their rights in relation to the detention process and the Mental Health Review Tribunal. However there was no evidence that the Resident Medical Officer (RMO) had discussions with the patient regarding their assessment for detention at each stage of the detention process or a record that the patient was unable to receive this information. This had been a previous recommendation and will be restated for a third time.

Information was displayed throughout the ward on the complaints procedure, the Mental Health (Northern Ireland) Order, and the advocacy service. It was good to note that there was a complaints booklet which was in a simplified format. There was also an information booklet on the bluestone unit in each patient's bedroom.

An independent advocate from NIAMH attends the ward on Tuesday and Thursday each week. The inspector met with the advocate who advised that they meet with all new patients on the ward to offer them the advocacy service, and they also attend the patient meetings on the ward each month.

Exit from the ward was locked. The inspector observed that patients were accommodated by nursing staff to leave the ward with their family/relatives. The ward manager advised that patients are encouraged to have time off the ward when this has been agreed at the multi-disciplinary meetings. Patients could also use the facilities on offer such as the coffee shop and the hospital canteen. The inspector met with two patients who advised that they had regular time off the ward and one patient advised that they had no concerns about the ward being locked as they can ask the nurse to open the door at any time.

The inspector reviewed three sets of patients' care records and there was evidence to confirm that two of these patients had been detained under the Mental Health (Northern Ireland) Order 1986. Both patients had core care plans in place in relation to their detention which detailed each step of this process and they also had individualised care plans in place from their assessed need.

In the three sets of care documentation reviewed by the inspector there were no care plans in place which considered patients deprivation of liberty. There were a number of patients on the ward who were not detained in accordance with the Mental Health (Northern Ireland) Order 1986 and had been deprived of their liberty by being nursed in a locked ward. However there was no evidence to show how staff were upholding patients' rights in relation to this. A recommendation has been made in relation to this.

However, there was one restrictive practice care plan in place in relation to a patient's use of cigarettes but the rationale around this level of restriction was unclear. When this restriction was discussed with the ward manager they advised that the patient had been assessed as lacking capacity to understand their care and treatment and there were risks associated with them smoking. However this was not detailed in the patients care plan and there was no evidence of that a best interest care pathway had been followed. A recommendation has been made in relation to this.

The inspector reviewed the ward's incident reporting procedure and there was evidence that incidents were completed appropriately and in accordance to regional and Trust policy.

The ward manager informed the inspector that there were no patients on the ward whose discharge was delayed.

There was evidence in one set of care documentation reviewed by the inspector that a patient was ready for discharge. This had been discussed at the multi-disciplinary ward meetings and a discharge plan had been completed. There was evidence of links made with the community occupational therapist, the community mental health team and with the patient's GP. The patient was given a four week outpatient review appointment and there was evidence that staff had involved the patient and their family in discussions regarding the discharge process.

There was another patient on the ward whose discharge plans had been commenced as a suitable placement had been agreed by the patients' family. The ward manager stated that this patient had been assessed as not having the capacity to understand their care and treatment. However there was no evidence of the outcome of a capacity assessment in the patient's care records. There had been some discussions with family members with regard to future accommodation however there was no evidence of a 'best interest' care pathway having been arranged to discuss and plan the patient's discharge even though accommodation had been sourced by the family. A recommendation has been made in relation to this.

The inspector spoke to one patient who stated that plans were in place for them to be discharged to a residential home. This patient advised that they had attended meetings regarding their discharge with their family and the multidisciplinary team. The patient stated they were happy with the plans that had been put in place and stated they felt fully involved in the process.

The ward manager informed the inspector that the psychiatry old age team leader from the community attends all three multidisciplinary team meetings each week as the ward covers three areas in the community. They liaise with patients' keyworkers in the community to ensure that relevant information is passed on and they advise them when patients are medically fit for discharge so that they can attend the weekly ward meeting to discuss and plan for patients' discharge.

The ward manager advised that all delayed discharged are reported to the Health and Social Care Board.

Details of the above findings are included in Appendix 2.

On this occasion willow 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	**2**
Relatives	**3**
Other Ward Professionals	**1**
Advocates	**1**

Patients

Both patients informed the inspector that they knew why they were in hospital and knew what they could and could not do on the ward. They stated they had been involved in their care and treatment and were able to involve their family members when they wanted to involve them. They advised that the nurses and doctors had spoken to them about their illness and their medication. Both patients informed the inspector that they felt safe on the ward. When discussing their overall care and treatment on the ward they made the following statements:

"they have worked a miracle with me, at my own pace", "nurses are very good there is always someone who comes in for a chat everyday"

"all the staff are very good on the ward"

Relatives/Carers

The inspector spoke to three relatives on the day of the inspector. All three relatives spoke very highly with regard to the care their relative had reviewed on the ward. Comments included:

"X tells us how good the ward is and how good the staff are, X always speaks positive about the care"

"X gets on well with the nurses"

"X has made good progress…… their medication has been changed"

One relative raised concerns regarding items going missing from their relative's room. This had been raised with staff and the items had been found in another patient's room. They advised that their relative was not able to lock their bedroom door and therefore they were concerned that other items may be taken. A recommendation has been made in relation to this.

Ward Staff

The inspector met with two nurses who were able to describe how they gained consent from patients prior to completing any nursing task. If patients refused they advised that they respected the patients' decision and would try to encourage them at a later point in the day. The two nurses advised that they had good relationships with all the multi-disciplinary team members. Both nurses stated that they enjoyed working on the ward.

Other Ward Professionals

The inspector met with the occupational therapy team leader. Who described the role and function of the occupational therapist and the technical instructor. They described the assessment process and how therapeutic activities and programmes to promote patients' independence and rehabilitation are set up from assessments.

Advocates

The inspector met with an advocate from NIAMH on the day of the inspection. They advised that they attend the ward twice a week. They meet all new patients on the ward to advise them of the service they can offer. They advised that they have in the past assisted patients with completing an application for the Mental Health Review Tribunal, given information on solicitors in the local area, linked in with the patients' community keyworker on behalf of patients and assisted patients with making complaints. If patients raise issues of concern to the advocate they discuss this with the ward manager who can deal with the issues appropriately.

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	10	8
Other Ward Professionals	5	0
Relatives/carers	20	2

Ward Staff

There were eight questionnaires returned from nursing staff in advance of the inspection. Information contained within the questionnaires indicated that five ward staff had received training in capacity to consent and had attended training on human rights. Seven stated that they were aware of the Deprivation of Liberty Safeguards (DOLS) – interim guidance and six staff members indicated they had received training in relation to restrictive practices. Out of the eight questionnaires returned seven staff indicated they had received training on meeting the needs of patients who need support with communication and all eight staff members indicated that patients'

communication needs were recorded in their assessment and care plans and that they were aware of alternative methods of communicating with patients. They all indicated that these methods were used on the ward. Seven ward staff reported that the level of therapeutic and recreational activities meets the patients individual needs on the ward.

Relatives/carers

Two questionnaires were returned by relatives in advance of the inspection. It was good to note that both relatives indicated that they felt the care on the ward was excellent. Relatives stated that:

" We find the entire staff caring and very professionals and cannot speak highly enough of them"

"My X has been in mental health wards for the last 20 years. The Willow ward provided the best nursing care ever experienced in hospital. They are an example to other wards on patient care"

Both relatives stated that they had been given the opportunity to be involved in decisions in relation to their relatives care and treatment. One relative indicated that their relative had an individual assessment completed in relation to therapeutic and recreational activities. One relative stated that their relative did not participated in activities on the ward.

7.0 Additional matters examined/additional concerns noted

Complaints

The inspector reviewed complaints received by the ward between 1 April 2013 and 31 March 2014. There were three complaints received over this period of time by patients and had been fully resolved to the satisfaction of the complainant and in accordance with trust policy and procedures.

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
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Appendix 1

Follow-up on recommendations made following the announced inspection on 9 and 10 July 2012

No.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	It is recommended that all policies and procedures are subject to a systematic and comprehensive three yearly review.	The inspector reviewed the policies and procedures on the ward and noted they had not been subjected to a systematic and comprehensive three yearly review. This was discussed at the conclusion of the inspection with the patient flow and bed management coordinator and the ward manager who advised that the Trust is working on updating these documents. However, they were not able to give a date for the completion of this work. This recommendation will be restated for a third time.	Not met
2	It is recommended that it is recorded when patients are not able to avail of the written information about detention.	There was evidenced in care records reviewed by the inspector that staff had recorded when patients were unable to avail of written information about the detention process. This was in relation to patients' literacy skills.	Fully met
3	It is recommended that the RMO records discussion regarding their assessment for detention at each stage of the detention process or a record that the patient was unable to receive this information.	The inspector reviewed two sets of care records of patients who had been detained in accordance with the Mental Health (Northern Ireland) Order 1986. There was no record of the RMO having had discussions with patients at each stage of the detention process. This was discussed at the conclusion of the inspection with the patient flow and bed management coordinator and the ward manager who advised that they will raise this at the next governance meeting to ensure that this is implemented. This recommendation will be restated for a third time.	Not met
4	It is recommended that patients	There was evidence in the multidisciplinary ward round	Fully met

	are given a choice to attend the MDT and this choice is recorded on a weekly basis.	template of three sets of care records reviewed by the inspector, that patients had been given the choice to attend the weekly ward round. Patients who spoke to the inspector stated that they had regularly attended their MDT meetings.	
5	It is recommended that the information about a patients physical status is clarified in the notes. (2)	The inspector reviewed three sets of care records and there was evidence that patients' physical status was clarified in each care record. This was detailed in the patients' medical and nursing assessments and care plans were in place to direct the care on the ward in relation to patients' physical health care needs.	Fully met
6	It is recommended that the programme of planned upgrading of refurbishment works (painting) is recommended. (2)	The inspector was informed that the ward had been refurbished (painted) and there were plans in place to decorate the patients' rooms. The inspector observed the ward environment and noted no concerns in relation to decoration. The inspector spoke to patients on the ward and relatives who raised no concerns regarding the décor of the ward.	Fully met
7	It is recommended that the ward manager ensures that all staff have formal supervision meetings and appraisal in accordance with policies and procedures.	The inspector reviewed records of formal supervision meetings and appraisals for staff. These records indicated that all staff had received supervision and appraisals in accordance with policies and procedures	Fully met
8	It is recommended that the ward manager reviews the format of formally recorded staff supervision to increase the opportunity for individual supervision.	The ward manager informed the inspector that they had reviewed the format of formally recorded staff supervision to increase the opportunity for individual supervision. Out of the 27 staff on the ward 17 had received one to one supervision and 10 members of staff had received group supervision which was in accordance with Trust policy and	Fully met

		procedures.	
9	It is recommended that the ward manager reviews training records to identify any gaps in training, knowledge and skills, in fire awareness and infection prevention and control and sets out a plan to address any deficits in training.	The inspector reviewed the training matrix for the ward and there was evidence that staff had attended training in relation to fire awareness and infection prevention and control. A ward clerk was on the ward for one day each week. Part of their role is to look at the training records to identify any gaps in staff training, knowledge and skills. From this a plan is devised to address any deficits in training. The training matrix is kept up to date to record training received by staff.	Fully met
10	It is recommended that the ward manager ensures that the need to record use of restraint and the format for recording use of restraint is reviewed in line with best practice guidance, and clarified and communicated to all staff.	The inspector reviewed the ward's incident reporting procedure. Incident reports were completed on the Trust's DATIX system. Reports were completed appropriately and in accordance to regional and Trust policy. Incident reports detailing the use of a physical intervention included the use of a physical intervention records which were scanned and copied to the DATIX system. A copy was also stored in the patients' care records. Incident reports were reviewed by the ward manager and forwarded to the Trust's governance department.	Fully met
11	It is recommended that a system to provide the ward manager with information in relation to review and outcomes of accidents, incidents and near misses that may influence ward practices is implemented.	The inspector reviewed the ward's processes for recording and reporting outcomes of accidents, incidents and near misses. These were all recorded on the Trust's DATIX system. This information was reviewed at the quarterly governance meetings. The ward manager informed the inspector that they attend these meetings and if changes are agreed in relation to ward practices this is implemented and staff are informed. The inspector reviewed minutes of governance meetings and staff meetings and there was	Fully met

		evidence of discussions regarding accidents, incidents and near misses.	
12	It is recommended that the ward manager ensures that information is made available to patients to inform them of their right to access information held about them.	On the days of the inspection this information was not available for patients. The ward manager stated that they would ensure that this information was available by displaying posters and informing the patients on admission. This recommendation will be restated for a second time.	Not met
13	It is recommended that the ward manager ensures information in relation to the locked environment is made available to patients and visitors.	Information regarding the locked door on the ward was included in the ward information booklet. There was also a sign next to the ward door to inform visitors of the locked door on the ward	Fully met
14	It is recommended that the ward manager devises a local procedure that reflects the current ward practices and mechanisms in place for the handling of vulnerable adults' monies and property.	This was discussed at the conclusion of the inspection with the patient flow and bed management coordinator and the ward manager who advised that a uniform policy for managing patients' finances within the bluestone unit will be available in May 2015. Therefore a local policy cannot be devised until the Trust develops this overall policy for the bluestone unit. The ward manager advised that when this policy is available in May 2015 they will devise a local policy for the ward. The ward manager informed the inspector that the ward no longer holds patients' money. This recommendation will be restated for the second time along with the second recommendation from the finance inspection dated 6 January 2014.	Not met
15	It is recommended that the ward manager reviews the format of the	The inspector reviewed format of the ward information booklet. This is a new booklet that has been developed by	Fully met

	ward information booklet to increase the font size of the print.	the bluestone hospital and the font size had been increased**.** Patients who spoke to the inspector raised no concerns regarding accessing information from this booklet**.**	
16	It is recommended that the ward manager reviews the social work arrangements for the ward to ensure all social work needs are met and patients are not disadvantaged by the absence of a dedicated ward social worker.	A dedicated social worker is not attached to the ward. However, the inspector discussed this with the ward manager who advised that the ward is able to make a referral when social work support is requested or recommended by the multidisciplinary team. The ward manager and the approved social work lead/ mental health social work co-ordinator for bluestone informed the inspector that the Bluestone unit has three social workers covering wards. One covers the PICU ward and the other two cover all other wards on the Bluestone site. The ward manager and the approved social work lead/ mental health social work co-ordinator for bluestone advised that referrals have been made in the past and patients have received adequate social work support when needed. The psychiatry old age team leader from the community also attends all three multidisciplinary team meetings each week as the ward covers three areas in the community (Armagh/Dungannon, Craigavon/Banbridge, Newry/Mourne). They liaise with patients' keyworker in the community to ensure that relevant information is passed on. The ward manager and the approved social work lead/ mental health social work co-ordinator for bluestone advised that the majority of patients on the ward have keyworkers in the community who are very involved in patients' care and are able to offer support. All statutory work is completed by social workers from the ward when	Fully met

		the need arises. The ward manager advised they contact the social work team to make a referral when this is requested.	

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

No.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	It is recommended that the ward manager ensures that all items brought into the ward on admission are listed appropriately, the area of their storage or transfer recorded, and appropriate receipting undertaken, particularly when relatives remove items from the ward.	Items of value that are brought into the ward on admission are recorded in a book and signed by the nurse and patient. A receipt is then given to the patient and the patient takes responsibility for they own items. However patients are encouraged to leave items of value at home or to send items of value home with their relatives/carers. When patients' relatives/carers remove items this is recorded in the patients' progress notes. A new patient property policy is being developed for the ward and will be available in May 2015	Fully met
2	It is recommended that the Trust develops and implements a uniform policy for managing patient's finances within the Bluestone Unit.	As stated above this was discussed at the conclusion of the inspection with the patient flow and bed management coordinator and the ward manager who advised that a uniform policy is being devised for the bluestone unit and should be available by May 2015.	Not met
3	It is recommended that the ward manager ensures that all staff attend relevant training in policies and procedures for management of patients finances.	Staff have not received training in relation to the policies and procedures for management of patients' finances. However, the patient flow and bed management coordinator and the ward manager advised when the local policy is available to staff this will be implemented. However they were unable to give a date of when this training will be available to staff. This recommendation will be restated for a second time	Not met
4	It is recommended that the ward manager ensures that appropriate systems are put in place to record	The ward no longer purchases items on behalf of patients. If patients need items they ask their relatives to bring them	Fully met

	purchases made by staff on behalf of patients with related receipts. Appropriate, detailed and verified records of transactions must be maintained	in or a staff members will accompany them to the local shop. Patients who have access off the ward go to the local shop and purchase their own items. The ward manager advised that if patients had no way of getting items from the shop and could not go with staff they would arrange for staff to purchase items on behalf of patients. If this occasion arises they will record this with the amount of money spent, obtaining the receipt to verify transactions.	

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	SAI 37 246	(No Recommendations – as no report has been received)	N/A	N/A

Quality Improvement Plan

Unannounced Inspection

Willow Ward, Craigavon Area Hospital

19 & 20 March 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 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 (f)	It is recommended that all policies and procedures are subject to a systematic and comprehensive three yearly review.	3	24 April 2015	In line with assurances given to RQIA following recommendations made, SHSCT is reviewing policies and procedures. Key policies and procedures have been identified and prioritised.
2	5.3.1 (f)	It is recommended that the RMO records discussion regarding their assessment for detention at each stage of the detention process or record that the patient was unable to receive this information.	3	Immediate and ongoing	I have addressed this with the consultants and this has been escalated to the Associate Medical Director to ensure compliance.
3	6.3.2 (b)	It is recommended that the ward manager ensures that information is made available to patients to inform them of their right to access information held about them.	2	Immediate and ongoing	Information is displayed on the noticeboard and in the information booklet telling patients how they can access information the SHSCT holds on computer and in paper records.
4	5.3.1 (f)	It is recommended that the Trust develops and implements a uniform policy for managing patient's finances within the Bluestone Unit. When this policy is implemented it is recommended that the ward manager devises a local procedure that reflects the current ward practices and mechanisms in place for the handling of vulnerable adults'	2	30 June 2015	This policy will be reviewed by the Finance Department by the end of May 2015.

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
		monies and property.			
5	4.3 (m)	It is recommended that the ward manager ensures that all staff attend relevant training in policies and procedures for management of patients finances	2	31 August 2015	Finance Department have committed to providing this training once the policy has been reviewed at the end of May 2015.
6	5.3.1 (f)	It is recommended that the ward manager ensure that patients' capacity to consent to care and treatment is monitored and re-evaluated regularly by the multidisciplinary team throughout patients' admission and that this is documented clearly in the patients care documentation.	1	Immediate and ongoing	Will be reviewed weekly at multidisciplinary team meeting. All members of the multidisciplinary team have been made aware of the need to record the details of the review.
7	5.3.1 (f)	It is recommended that the ward manager ensures that when patients have been assessed as not having capacity in a specific area. That a best interest decision care pathway is set up and followed as outlined in the March 2003 Reference Guide to Consent for Examination, Treatment and Care.	1	Immediate and ongoing	Multidisciplinary team will be reminded of their responsibilities to set up a best interest care pathway for those lacking capacity.
8	5.3 1 (f)	It is recommended that the ward manager ensures that each section on the 'weekly ward meeting' template is complete in full. This	1	Immediate and ongoing	All staff within the multidisciplinary team are being made aware of this recommendation through ward/staff meetings

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
		should include details of patients' attendance/non-attendance with the reasons why and the agreed outcomes/actions of the meeting.			and meetings with ward sister/consultant.
9	5.3.3.(b)	It is recommended that the ward manager ensures all nursing care plans are reviewed and updated in line with trust policy and professionals guidelines. Multi-disciplinary team decisions regarding changes in care plans should be documented with the involvement of the patient.	1	Immediate and ongoing	The recommendation has been brought to the attention of all staff. The ward sister is ensuring that the patient record is audited to ensure compliance.
10	5.3.1 (f)	It is recommended that the ward manager ensures that patients' capacity to consent to care and treatment is clearly documented in the patients' care records detailing the specific area assessed. This should include reference to care planning decisions made by, or on behalf of, the patient.	1	30 June 2015	See recommencation No: 7 Each patient will be reviewed at multidisciplinary to ensure that capacity to consent is clearly documented and this is reflected in the care plan.
11	5.3.1 (f)	It is recommended that the ward manager ensures that all progress notes completed by nursing staff detail ongoing evaluation of patients' care, in relation to each individual care plan.	1	Immediate and ongoing	Please see response to No: 9 recommendation

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
12	5.3.1 (c ,f)	It is recommended that the ward managers ensures that when patients are assessed as requiring a profiling bed that a risk assessment is completed for each individual patient and reviewed regularly in accordance with the safety alert issues on 23/12/13 by the Northern Ireland Adverse Incident Centre (NIAC) Estates Facilities Alert /2010/006 associated with profiling beds.	1	Immediate and ongoing	All risks are currently identified through the individuals promoting quality care documentation Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services May 2010. The management of any identified risk is recorded in their risk management / recovery care plan. The Trust reviewed the use of profiling beds and concluded that there was sufficient on going clinical need in this group of patients, that required profile beds to remain in Willows. The Trust recognises the risks associated with profiling beds. This risk is recorded on the ward's risk register and is identified in the environmental ligature risk assessment. Control measures have been put in place whereby any patient admitted to Willows will have a specific reference on the ligature risk from a profile bed recorded in their risk documentation. Any identified risk will record an associated management plan . All risks are reviewed at the weekly multi-disciplinary meeting. Risk assessment and management is a live continuous process and as risk changes for the patient, their risk management plan evolves in reponse to the identified change in risk.
13	5.3.1 (f)	It is recommended that the ward	1	Immediate	Arrangements are being put in place for the OT instructor to

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
		manager ensures that the technical instructor records in each patient's care documentation their progress or participation in therapeutic activities.		and ongoing	access the PARIS care record and update in line with recommendation. In the meantime she will report to the named nurse so the nurse will update the record.
14	5.3.1 (a)	It is recommended that the ward manager ensures that each patient has an occupational therapy assessment completed and if they decline this assessment this is record in their care documentation. If patients have an assessment in place and still decline therapeutic activities this should also be recorded in the patients' care records with the reason why.	1	30 June 2015	All patients have an assessment carried out and are encouraged to avail of the ward programme. The recommendation has been brought to the attention of the OT/nursing staff, and if patients decline activities/altenatives offered then this will be recorded in this patients record.
15	5.3.3 (b)	It is recommended that the ward manager ensures that all patients have an individualised recovery focused therapeutic/recreational care plan in place which is monitored and reviewed on a regular basis.	1	30 June 2015	This will be incorporated into the patients recovery care plans. Working group set up as to how best to implement this.
16	6.3.1 (a)	It is recommended that the Trust reviews psychology input to the ward to ensure patients are receiving adequate support when an inpatient.	1	30 September 2015	The Trust is recruiting a psychologist for the Bluestone inpatient wards.
17	5.3.1 (a)	It is recommended that the Trust ensures that Deprivation of Liberty	1	15 May 2015	Training days have been commissioned for staff, a working

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
		Safeguards (DOLS) – Interim Guidance, as outlined by the DHSSPSNI in October 2010, is implemented within willow ward			group has been set up within the unit to guide staff in the implementation of Deprivation of Liberty Safeguarding care plan.
18	5.3.1 (a)	It is recommended that the ward manager ensures that when restrictive practices are in place, individualised care plans are developed detailing the rationale for the level of restriction in terms of necessity and proportionality. Care interventions aimed at reducing levels of restriction should also be included.	1	Immediate and ongoing	Please see response to No: 17 recommendation
19	5.3.3.(b)	It is recommended that the ward manager reviews the practice in relation to patients holding their key to their bedroom door. This should be considered on an individual patient basis to consider managing risks and upholding patients' human rights.	1	31 August 2015	None of the bedroom doors are locked and patients do not hold a key to the room at any time. However at times patients will request that their room is locked when not in use and the ward Sister will ensure that patients are aware they can request this. The Ward Sister has reviewed this and the locks on patient doors are not individual. To issue a patient with a key would compremise the safety and security of patients and the staff. E.g. this would give the patient access to the clinic room and

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
					other non patient areas, as well as other patient's rooms.

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	MARY DONNELLY
NAME OF CHIEF EXECUTIVE / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	MICEAL CRILLY

Inspector assessment of returned QIP				**Inspector**	**Date**
		Yes	**No**		
A.	Quality Improvement Plan response assessed by inspector as acceptable	x		Audrey McLellan	**5/6/15**
B.	Further information requested from provider				