Willow Ward

Craigavon Area Hospital

Southern Health and Social Care Trust

Unannounced Inspection Report

Date of inspection: 29 July 2015

informing and improving health and social care
www.rqia.org.uk

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Our Vision, Purpose and Values

Vision

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

Purpose

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

Values

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

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

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

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1.0 Introduction

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

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

Is Care Safe?

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

Is Care Effective?

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

Is Care Compassionate?

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

2.0 Purpose and Aim of this Inspection

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

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 inspector do:

- reviewed the quality improvement plan sent to RQIA by the Trust following the last inspection(s)
- 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 inspector:

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

After the inspection the ward staff will:

- send an improvement plan to RQIA to describe the actions they will take to make any necessary improvements

3.0 About the ward

Willow Ward provides psychiatric assessment, care and treatment to patients aged 65 years and over. The ward can also accommodate five patients aged 50 -64 years. There were seventeen patients on the day of the inspection; three patients were detained in accordance with the Mental Health (NI) Order 1986.

Patients have access to a multi-disciplinary team consisting of psychiatry, medical, nursing, occupational therapy and social work. Access to psychology, physiotherapy, speech and language therapy and dietetics is by referral.

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

4.0 Summary

Progress in implementing the recommendations made following the previous inspection carried out on 19 & 20 March 2015 were assessed during this inspection. There were a total of nineteen recommendations made following this inspection. It was good to note that thirteen recommendations had been implemented.

Three recommendations had been partially met and three recommendations had not been met. These recommendations will be restated for a second time following this inspection.

Two new recommendations have been made from the inspection findings. These are in relation to ligature risks and the completion of the electronic care record system (PARIS).

Inspectors noted that patients mental health and recovery plans were recorded on the PARIS system. A full time occupational therapist had been recruited and was scheduled to commence employment in the Bluestone unit in August 2015.

The lay assessor met with three patients and two relatives on the ward. Patients and relatives spoke positively about the staff on the ward. Both patients and relatives indicated that care was safe, effective and compassionate.

The ward environment was observed to be fit for purpose and delivered a relaxed and safe environment.

Staff were observed engaging positively with patients. Staff were attentive and promptly responded when patients required support with their care needs.

All beds on the ward were profiling beds. Profiling beds were included in the trust risk register and each patient had a risk assessment and care plan in place to manage the risk of self harm. However, these had not been consistently reviewed along with the mental health recovery plans every week. The ward environmental risk assessment and action plan was also not up to date and did not include profiling beds.

4.1 Implementation of Recommendations

Five recommendations which relate to the key question "**Is Care Safe**?" were made following the inspection undertaken on 19 & 20 March 2015

These recommendations concerned the updating of trust policies and procedures, the management of patients' finances, informing patients throughout the detention process and how the risks associated with profiling beds was managed on the ward.

Inspectors were pleased to note that three recommendations had been implemented. The trust had reviewed the relevant policies and procedures, and had developed a policy for managing patients' finances. The RMO had recorded discussions with patients who were detained at each stage of their detention processes.

However, despite assurances from the Trust, one recommendation had not been fully implemented. Staff had not consistently reviewed care plans in place for the risks associated with the use of profiling beds.

Nine recommendations which relate to the key question "**Is Care Effective**?" were made following the inspection undertaken on 19 & 20 March 2015.

These recommendations concerned the completion of patient care documentation, patients access to recreational and therapeutic activities, the absence of occupational therapy assessments and psychology services. Recommendations were also made in relation to implemtening Deprivation of Liberty Safeguards (DOLS) on the ward and the completion of care plans in relation to restrictive practices.

The inspector was pleased to note that four recommendations had been implemented. The weekly ward meeting template had been completed in full, and staff had recorded patients' attendance at these meetings. Staff had recorded a daily evaluation of the patients' care. Plans were in place to recruit a psychologist to the Bluestone unit. Patients who were assessed as requiring a any form of restrictive practice had an individualised restrictive practice care plans in place.

However, despite assurances from the Trust, five recommendations had not been fully implemented. Not all care plans were consistently reviewed every week. The technical instructor was not recording patients' progress in their case notes. None of the patients had an occupational therapy assessment completed in relation to recreational and therapeutic acitivities. Patients did not have a recovery focused therapeutic / recreational care plan in place. Deprivation of Liberty Safeguards (DOLS) was not fully implemented within the ward.

Five recommendations which relate to the key question "**Is Care Compassionate**?" were made following the inspection undertaken on 19 & 20 March 2015.

These recommendations concerned patients' rights to access information held about them, capacity and consent and patients locking their bedroom doors.

The inspector was pleased to note that all of the recommendations had been implemented. There was information available for patients informing them on how to access information held about them. Patients capacity to consent was assessed, monitored and reviewed every day by nursing staff and weekly by the multi-disiplinary team. Patients could request for nursing staff to lock their bed room doors..

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

Summary

The inspector noted that there was information displayed on the purpose of the ward. The ward also had an information booklet which was up to date. There was no information displayed on the ward's performance.

The inspector reviewed the staffing levels on the ward; no concerns were identified. Staffing levels appeared adequate to support the assessed needs of the patients. Staff were observed to be attentive and assisted patients promptly when required. Staff were observed supporting patients with recreational activities. It was good to note that the ward had introduced a coffee morning whereby patients' relatives/carers were asked to call into the ward to join staff and patients for a coffee.

The ward environment was clean and clutter free. There was ample natural lighting, good ventilation and neutral odours. Ward furnishings were well maintained and comfortable. It was good to note that the ward had been painted and poems and positive words of encouragement were displayed throughout the ward which patients had completed with staff.

The ward environment promoted patients' privacy and dignity. Patients had their own individual ensuite bedrooms. Additional bathroom and toilet facilities were accessible. Patients could lock bathroom doors and a call system was available. There was a private room for children to visit and visitors could also come onto the ward. The entrance doors to the ward were locked at all times. Each patient had deprivation of liberty care plans in place in relation to this restriction.

There were no areas of overcrowding observed on the day of the inspection; the day areas were open, spacious and the furniture was arranged in a way that encouraged social interaction. There were smaller areas for patients to sit and form friendships. The inspector observed that staff were present at all times in the communal areas and available at patients' request. A garden area was noted to be open and accessible throughout the inspection.

Confidential records were stored appropriately and patient details were not displayed. Signage was available throughout the ward.

There was up to date and relevant information displayed in the communal areas and available in the ward welcome / information pack. This included the following information; Human Rights, patient rights in accordance with the Mental Health (Northern Ireland) Order 1986, the right to access patient information, independent advocacy services and the right to make a complaint.

The medical room was clean, tidy and well organised. The inspector reviewed the last ligature risk assessment and action plan which was completed on 2012 and therefore required to be updated.

There was evidence that care plans/risk assessments were in place in relation to patients using profiling/metal frame beds. However these were not recorded on the PARIS system as part of the patients' Mental Health and Recovery plan.

Patient activities and day care schedules were displayed in patients' bedrooms, on the activity room door and in pictorial format on a large notice board on the ward. Patients did not have individualised recovery focused therapeutic/recreational care plan in place. A recommendation will be restated in relation to this.

The day, date, month, year and weather was communicated on the ward's notice board.

Patients were observed during lunch time in a clean and comfortable dining area. A choice of meals was available and staff were observed offering patients choice.

The inspector identified a number of areas which should be reviewed by the ward manager to improve standards on the ward in accordance with good practice guidance. These include:

- Displaying information about the ward's performance e.g. information in relation to incidents, compliments and complaints.
- Details of the ward doctor and other members of the multi-disciplinary team should be displayed on the notice boards
- Staff should record when activities have been cancelled with the reason why. There should also be a mechanism for informing patients .

The detailed findings from the ward environment observation are included in Appendix 2

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 inspector completed a 20 minute 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

The formal session involved an observation of interactions between staff and patients/visitors. Five interactions were noted in this time period. The outcome of these interactions were as follows:

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

Overall the quality of interactions between staff and patients were positive. Patients and nursing staff were observed sitting together in the communal area. The atmosphere was relaxed with visitors coming on to the ward sitting chatting with patients in various different areas within the ward. Staff were available and were prompt in assisting patients throughout the observations

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

7.0 Patient Experience Interviews

Three patients agreed to meet with the lay assessor to complete a questionnaire regarding their care, treatment and experience as a patient.

One relative agreed to meet with the inspector to talk about the care and treatment on the ward.

Overall responses were positive. Patients stated they felt safe and secure and had been informed of their rights. Patients indicated that care was mostly effective. All patients stated they were involved in their care and treatment plans. Two patients were informed of results from assessments, one patient had to ask for results but stated that staff did explain them. Staff sometimes discussed with the patients how they were progressing. Patients indicated that activities were available on the ward, but sometimes did not happen. One patient stated that they are not interested in the activites available. Patients felt that being on the ward has helping them to recover. Two patients stated staff were supportive and helpful on admission. One patient stated that staff

did not take time to introduce themselves on admission to the ward. All patients comfirmed that care was compassionate. Patients stated staff were warm, empathetic, respectful and treated them with dignity and respected their privacy. All patients stated staff listen to them and also give an explanation before supporting them with care and treatment.

Patient quotes;

"The ward is comfortable, food is good…"

"Experience here has been positive and I am ready to go home. Also I developed a chest infection first week of admission which was quickly diagnosed and treated successfully"

"Good supportive medical, nursing and domestic staff"

The relative felt that the environment could be more stimulating and cheerful. The relative stated there family member felt alone at night and had preferred the "old system " of four bedded bay areas as "patients could support each other".

The detailed findings are included in Appendix 4.

8.0 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 23 September 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 – Ward Environment Observation

This document can be made available on request

Appendix 3 – QUIS

This document can be made available on request

Appendix 4 – Patient Experience Interview

This document can be made available on request

Appendix 1

Follow-up on recommendations made following the announced inspection on 19 and 20 March 2015

No.	Reference.	Recommendations	Number of time stated	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	5.3.1 (f)	It is recommended that all policies and procedures are subject to a systematic and comprehensive three yearly review.	3	The Head Of Acute Mental Health Services confirmed that the following policies and procedures had been reviewed and would be ratified by the trust, week ending 7 August 2015. • Continuous Observations • Search Policy • Admission & Discharge • Child Visiting • Bed Management Protocol • Procedure for Locked Doors • Procedures for Patients Private Property The Admission/Discharge policy was still in draft format and will be presented at the Acute Governance Forum on 24th August 2015.	Met
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	All care records are documented on the electronic care recording system (PARIS). The inspectors were informed that an audit had been completed in relation to this recommendation. This was not available on the day of the inspection. However inspectors reviewed care documentation in relation to two patients who were detained in accordance with the Mental health (Northern Ireland)	Met

				Order 1986 and noted the RMO had discussed the assessment for detention at each stage of the detention process with both patients.	
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	The inspectors noted that information was available for patients to inform them of their right to access information held about them. This was displayed in the ward communal area, and available in the ward information book.	Met
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' monies and property.	2	The ward manager stated that patients' money is not retained on the ward. A procedure was in place to direct staff on what to do when a patient is admitted with a large sum of money or valuable items. The inspectors reviewed the policy and procedure for managing patients' private property was issued in May 2015.	Met
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	The ward manager stated that staff had not received formal training in the management of patients' finances. However, the policy was circulated to staff for comments before it was issued in May 2015. The policy and procedure for managing patients'	Met

				private property was available for staff on the ward.	
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	Inspectors were informed by the ward manager that all patients on the ward on the day of the inspection had capacity to consent. Inspectors reviewed care documentation in relation to four patients on the ward. Staff had recorded that each patient had capacity to consent on admission. There was evidence that this was reviewed daily and also weekly at the patient's multi-disciplinary team meeting. Staff had recorded in the multi-disciplinary team meeting minutes whether the patient continued to have capacity to consent or if there were any changes to their capacity.	Met
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	Inspectors were informed by the ward manager that all patients on the ward have been assessed as having capacity. Therefore to date none of the patients had required a best interest decision care pathway. Staff spoken to were able to inform inspectors when a best interest decision pathway would be used and explained the procedure for using the pathway.	Met
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 should include details of patients' attendance/non-attendance	1	The inspectors reviewed the weekly multi-disciplinary team meeting template completed for four patients and noted that the template had been fully completed. Patient attendance or otherwise was recorded on the template. It was noted that all four patients had attended their multi-disciplinary team meetings.	Met

		with the reasons why and the agreed outcomes/actions of the meeting.			
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	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 the all of the electronic copies of patient care plans had been reviewed every 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. 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
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	The ward manager informed inspectors that all patients on the ward on the day of the inspection had capacity to consent. Inspectors noted that staff had recorded patients had capacity to consent in the four sets of care records reviewed. Patient's capacity to consent was clearly recorded on admission, assessed every week at the multi-disciplinary team meeting and documented. There was evidence that capacity and consent was monitored and evaluated every day by staff and	Met

				recorded in the daily case/progress notes.	
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	Inspectors reviewed case/progress notes in relation to four patients. Case/progress notes were noted to be comprehensive. Staff had documented an evaluation of patient's mental health and well-being and care delivered every day. Case notes detailed patient's mood, mental health, behaviour, compliance, activities of living and reflected the patients' assessed needs and care plans.	Met
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	All beds on the ward are profiling beds. Inspectors noted that the risk of self-harm from profiling beds was recorded on the trust risk register. The trust risk register was noted to be up to date and reviewed every three months. Inspectors reviewed the ward environmental suicide and ligature point risk assessment and action plan and noted this had not been updated since 16.05.12 and did not include profiling beds. Inspectors reviewed the risk assessments and care plans in place for self harm risks in relation to four patients. The risk of self harm was recorded in the patient's comprehensive risk screening tool. Each patient had a care plan in place that detailed whether the patient was at risk using a profiling bed. The action if there was a risk was recorded. These care plans were not recorded on the PARIS system. The care plans were	Partially met

				not reviewed weekly in line with the review of the remaining Mental Health and Recovery care plans recorded on the PARIS system. Therefore there could be a risk that any changes to the patients' mental health or risk of self harm identified during the weekly review of the patients mental health may have resulted in the risk assessment / care plan not being updated. This recommendation will be restated for a second time. A new recommendation will be made in relation ensuring the ward environmental suicide and ligature point risk assessment and action plan is reviewed and includes profiling beds.	
13	5.3.1 (f)	It is recommended that the ward manager ensures that the technical instructor records in each patient's care documentation their progress or participation in therapeutic activities.	1	Inspectors reviewed the care records in relation to four patients. Inspectors were informed by the patient flow and bed management co-ordinator that the technical instructor had received training in the use of the PARIS system and had access to record patient's progress. Inspectors noted the technical instructor had not documented patient's progress or participation in therapeutic activities. This recommendation will be restated a second time.	Not met
14	5.3.1 (a)	It is recommended that the ward manager ensures that each patient has an occupational therapy assessment completed and if	1	Inspectors reviewed the care records for four patients and noted that none of the patients had an occupational therapy assessment completed. There was no rationale recorded why each patient did not have an assessment completed i.e. patient had	Not met

		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.		declined. An occupational therapist has been recruited for the Bluestone unit and will start on 2 August 2015. This recommendation will be restated a second time.	
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	Inspectors reviewed the Mental Health and Recovery plans in relation to four patients. Two patients had a therapeutic and recreational care plan in place. However there was no evidence of occupational therapy (OT) assessments having been completed which would assist in devising appropriate therapeutic/recreational activities and goals for patients to work towards. Care plans were not comprehensive and did not detail how the activities listed supported the patient's with their recovery. The only detail recorded was a list of activities the patient liked to participate in. In relation to the other two care records reviewed there were no details recorded in the therapeutic and recreational care plan. This recommendation will be restated a second time.	Not met
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	Inspectors were informed by the patient flow and bed management co-ordinator and Head Of Acute Mental Health Services that the trust had reviewed the need for psychology input and were in the process of recruiting a full time psychologist for the Bluestone Unit.	Met

17	5.3.1 (a)	It is recommended that the Trust ensures that Deprivation of Liberty Safeguards (DOLS) – Interim Guidance, as outlined by the DHSSPSNI in October 2010, is implemented within willow ward	1	The locked door policy was reviewed in March 2015. Egress from the ward is controlled by staff via a swipe system. Three out of twenty patients on the ward were detained in accordance with the Mental Health (Northern Ireland) Order 1986. Progress was noted in implementing Deprivation of Liberty Safeguards. Inspectors noted in the four sets of care records reviewed that each patient had an individualised care plan in place in relation Deprivation of Liberty. Staff had also considered the impact on patients Human Rights. However, inspectors noted the following: It was not recorded if the patient required the secure environment; If the patient did not require the secure environment; the measures staff were taking to reduce the level of restriction was not recorded; If patients did require the secure environment the rationale recorded did not demonstrate if the restriction was necessary or proportionate to the risk; It was not recorded that patients who were voluntary should be informed that they can leave the ward at any time; This recommendation will be restated a second time.	Partially met
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	1	Inspectors reviewed risk assessments in place for two patients who were assessed as requiring restrictions. Staff retained smoking materials for one patient and an item that could have been used as a ligature for another patient.	Met

		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.		Each patient had a clear rationale in place that evidenced the restriction was necessary and was proportionate to the risk. The restrictions were reviewed every day and there was evidence that staff were proactively looking at ways to reduce the restriction.	
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	Inspectors were informed by the ward manager that the key to all patients' bedroom doors was a master key and therefore it would open all the bedroom doors in Willow. Patients can request their bedroom door is locked by nursing staff at any time. None of the patients on the ward expressed any concerns in relation to locking their bedroom doors.	Met

R3

Quality Improvement Plan

Unannounced Inspection

Willow Ward, Craigavon Area Hospital

29 July 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 the ward manager, the head of acute mental health services 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 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 ,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.	2	Immediate and on-going	On admission each patient is assessed for the use of profiling beds and the Trust recognises that they are in use on Willows Ward. They are on the Risk Register and a Ward Environmental Suicide and Ligature Point Risk Assessment and an Action Plan is in place. The care plans for use of profiling beds are now being recorded on PARIS in the Promoting Quality Care risk documentation and reviewed weekly at the multidisciplinary team meetings as are all risks routinely reviewed weekly.
2	5.3.1 (f)	It is recommended that the ward manger ensures that the ward environment and ligature point risk assessment and action plan is reviewed, updated and includes profiling beds.	1	Immediate and on-going	An Environmetal Suicide and Ligature Point Risk Assessment and Action Plan was completed on 25th August 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
Is Care Effective?					
3	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.	2	26 October 2015	All nursing care plans are reviewed and updated before the end of a shift if care needs change, or at least on a weekly basis if care needs have not changed substantially. All changes are documented in the Recovery Care Plan which the patient sees and signs that they are aware of and agreeing to the changes. This is also reflected in the weekly multidisciplinary sheet.
4	5.3.1 (f)	It is recommended that the ward manager ensures that the technical instructor records in each patient's care documentation their progress or participation in therapeutic activities.	2	Immediate and on-going	The Technical Instructor is now recording on PARIS a daily basis details of patient participation in Occupational Therapy/Recreational sessions. The Technical instructor and the Occupational Therapist (allocated to Willows 18hrs per week) meet on a weekly basis to discuss the patients progress and this information is fed back at multidisciplinary team meetings. The Technical Instructor explains the therapeutic

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
					programme to the patients and completes the interest check list.
5	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.	2	26 November 2015	Recreational activities that each patient engages in are reflected in their individual Recovery Care Plans. This is monitored and reviewed weekly.
6	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.	2	26 January 2015	Each patient 48hrs after their admission will have an Occupational Therapy assessment depending on their mental health status. Initial screening and initial interview will be completed and recorded. This will include assessment of mental state and functional transfers/mobility. Cognition screening will also be completed. Verbal consent is sought for all of this and recorded in the patients record on PARIS . From this the Occupational Therapist plans what further interventions may be required e.g. kitchen, dressing assessments and money management.

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
					The Occupational Therapist and nursing staff will explain therapeutic interventions to the patients and individuals are encouraged to attend. If patients decline, the Occupational Thearpist and nursing staff will speak with the individual and find out their likes and other means of helping them to participate. This will be discussed at multidisciplinary meetings and the Recovery Care Plan updated on a weekly basis.
7	5.3.1 (a)	It is recommended that the Trust ensures that Deprivation of Liberty Safeguards (DOLS) – Interim Guidance, as outlined by the DHSSPSNI in October 2010, is implemented within willow ward	2	26 October 2015	Deprivation of Liberty Safeguards are implemented within the Willows Ward and recorded on all patients in the Recovery Care Plan on PARIS in section 'Other' and reviewed and updated weekly or as required.
8	5.3.1 (a)	It is recommended that the ward manager ensures that all care plans are recorded on the patient electronic care record system (PARIS).	1	26 November 2015	All care plans are recorded on the patient 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 Compassionate?					
		There are no recommendations made in relation to compassionate care.			

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	Francis Rice

Inspector assessment of returned QIP				Inspector	Date
		Yes	No		
A.	Quality Improvement Plan response assessed by inspector as acceptable	✓		Wendy McGregor	**17 September 2015**
B.	Further information requested from provider				