The Regulation and Quality Improvement Authority

RQIA

Mental Health and Learning Disability

Unannounced Inspection

Acute Ward, Downe Hospital

South Eastern Health and Social Care Trust

11 and 12 November 2014

npm national preventive mechanism

informing and improving health and social care
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Contents

1.0 General Information

Ward Name	Downe Acute
Trust	South Eastern Health and Social Care Trust
Hospital Address	2 Struell Wells Downpatrick BT30 6RL
Ward Telephone number	028 4461 3311
Ward Manager	Neil Morgan
Email address	neil.morgan@setrust.hscni.net
Person in charge on day of inspection	Neil Morgan
Category of Care	Acute inpatient care
Date of last inspection and inspection type	10 October 2014 patient experience interviews
Name of inspector(s)	Alan Guthrie

2.0 Ward profile

Downe Acute is a 22 bedded mental health acute admission ward situated within the Downe Hospital. The ward is a mixed adult ward and can accommodate patients from the age of 18 years. On the day of the inspection there were seven patients admitted to the ward in accordance to the Mental Health (Northern Ireland) Order 1986.

The ward's multidisciplinary team consists of registered nurses, occupational therapy, social work, medical and psychiatry staff and members of the allied health professions. Advocacy services are available on the ward weekly for patients and their families.

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 **Downe Acute** was undertaken on **11 and 12 November 2014.**

4.1 Review of action plans/progress to address outcomes from the previous announced inspection

The recommendations made following the last announced inspection on the 9 and 10 May 2012 were evaluated. The inspector noted that 17 recommendations had been fully met and compliance had been achieved in the following areas:

- Nurse training records evidenced that nursing staff had completed their mandatory training including training in protection of vulnerable adults, child protection and care and responsibility;
- staff who met with the inspector demonstrated knowledge and understanding of the protection of vulnerable adults policy and procedures;
- all nursing staff had received their mandatory training. Allied health professionals who met with the inspector reported no concerns regarding the completion of mandatory training and records for training were retained by their professional lead;
- training with regard to vulnerable adult procedures was included in the Trust's corporate induction;
- records of all vulnerable referrals were retained on the Trust's MAXIMS system, which all staff could access;
- immediate prevention plans and increased supervision for patients presenting with risk regarding potential falls, were put in place as required and discussed with the charge nurse and consultant psychiatrist;
- patients were involved in their risk assessments and signatures were available on care records. Patient signatures were not always available on updated risk assessments as these were retained in electronic format. Entries in patient continuous notes recorded that patients had been involved in reviews of their risk assessments but could not sign their risk assessments as these were retained on the MAXIMS system;
- relatives were informed, with patient consent, of incidents and accidents involving a patient;
- the Trust's admission and discharge policy was available and up to date;
- the Trust's policy on the use of restraint in mental health inpatient units was available and up to date;
- records of patient property retained by staff were available and completed in accordance to Trust policy and procedures. This included entries recording when patient personal property was returned to the patient;

- the Trust's child visiting policy was easily accessible within the ward and displayed on the ward's main notice board;
- the area used for children visiting the ward was located away from the main ward, it was well lit, appropriately equipped and maintained to a good standard;
- 11 members of ward staff had completed training to enable them to supervise and induct patients on how to use the gym safely.

4.2 Review of implementation of any recommendations made following the patient experience interview inspection on 12 December 2013

The recommendation made following the patient experience interview inspection on 12 December 2013 was evaluated. The inspector was pleased to note that the recommendation had been fully met and compliance had been achieved in the following area:

- The patient and carer information booklet and the admission checklist used by staff evidenced that upon admission patients were informed about the advocacy service.

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

The recommendation made following the finance inspection on 3 January 2014 was evaluated. The inspector was pleased to note that the recommendation had been fully met and compliance had been achieved in the following area:

- The ward manager had ensured that a record of staff members who had obtained the key to the locked drawer was available and up to date.

4.4 Review of implementation of any recommendations made following the investigation of a Serious Adverse Incident

A serious adverse incident had occurred on the ward on 7 January 2014**.** Relevant recommendations made by the review team who investigated the incident were evaluated during this inspection. It was good to note that compliance had been achieved in the following areas:

- Occupational Therapy provision in the mental health inpatient unit provided services to patients in accordance to each patient's individually assessed needs;
- contact numbers of the various community mental health teams and the hours in which they are available, to include the arrangements for accessing mental health services out of hours, were available to patients and their relatives/carer.

4.5 Review of implementation of any recommendations made following the investigation of a Serious Adverse Incident

A serious adverse incident had occurred on the ward on 15 May 2014**.** Relevant recommendations made by the review team who investigated the incident were evaluated during this inspection. It was good to note that compliance had been achieved in the following areas:

- The ward manager and charge nurses were conducting a review of the nursing records of all patients admitted to the ward to ensure compliance with record keeping standards;
- nursing records reviewed by the inspector evidenced that all patients admitted to hospital in accordance to the Mental Health (Northern Ireland) Order 1986 had received a written copy of their rights and had been given the opportunity to discuss these with staff;
- the staff supervision template evidenced that practitioners records were audited. Practitioners who met with the inspector reported that their records were audited after a patient was admitted, monthly and twice yearly during supervision;
- NIPEC audits were completed monthly;
- incidents that occurred in the ward were reviewed by the multi-disciplinary team the following day. This included appraisal of records to ensure that all appropriate documentation had been completed and updated;
- care records reviewed by the inspector evidenced that nursing staff were providing patients with 1:1 time to discuss the patient's progress and to address any concerns the patient may have;
- carer contact was discussed at both supervision and ward team meetings and this was evidenced in the supervision template and in the minutes of previous ward team meetings;
- the Mental Health Hospital Services Manager had implemented key performance indicators to measure and review engagement with carers;
- staff who met with the inspector reported that they were familiar with deprivation of liberty standards (DOLS). Care documentation reviewed by the inspector evidenced that DOLS standards were being implemented and staff had considered patient's rights;
- the Trust's MAXIMs system had been updated to include information, where required, recording the levels of enhanced observation used with a patient;
- the Trust's estates department was continuing to explore the potential for introducing technology that will indicate if weight has been applied to an ensuite door.

4.6 Review of implementation of any recommendations made following the investigation of a Serious Adverse Incident

A second serious adverse incident had occurred on the ward on 15 May 2014**.** Relevant recommendations made by the review team who investigated the

incident were evaluated during this inspection. It was good to note that compliance had been achieved in the following areas:

- patient care records reviewed by the inspector evidenced that the use of physical intervention with a patient was recorded on a physical intervention monitoring form and on a Trust incident reporting form;
- all absence without official leave (AWOL) incidents were audited by the Trust. The ward manager had also introduced the anti-absconding work book for all staff;
- a "bring no plastic bags" policy had been considered and introduced within the ward.

Details of the above findings are included in Appendix 1.

5.0 Inspection Summary

Since the last inspection the ward has addressed a number of previous recommendations and implemented a number of positive changes. These have included enhancing patient involvement in their care and treatment, providing detailed information to patients regarding the mental health order, improving relatives involvement in patient care and securing the ward's outside areas.

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.

Information for patients regarding capacity and decision making was available in the patient and carer information booklet and on notice boards throughout the ward. Patients who met with the inspector reported that they felt safe on the ward and that they had been involved in decisions in relation to their care and treatment. Patients reported no concerns regarding their ability to meet with nursing staff, as required, and to accessing regular reviews with their consultant. The ward had introduced a 'think family project' to help ensure that relatives and carers were kept informed of decisions made regarding patient care and treatment and to address any concerns a relative or carer may have. It was good to note that a carer advocate was available and that patients were supported by two patient advocacy services both of which visit the ward on a weekly basis.

Patient progress was monitored daily by nursing staff, discussed at the multi-disciplinary team huddle meetings and reviewed weekly at each patient's team assessment meeting. Patient care documentation reviewed by the inspector was up to date and comprehensive. Patients initial assessments, risk assessments and care plans were retained on the Trust's MAXIMS patient information system. Patient's continuous care records were also available on MAXIMS and these evidenced that nursing, occupational therapy, social work and mental health community staff provided entries. However, the inspector noted that medical records were completed in handwritten format and retained in the patient's hardcopy file. Subsequently, information relating

to patient progress was stored in two separate locations. A recommendation has been made.

The ward's therapeutic and recreational timetable was available on the main notice board and at the entrance to the occupational therapy (OT) room. The OT room contained a wide variety of art and craft materials, audio visual equipment, two computers for patient use and a selection of board games. Activities were provided on a daily basis and included creative, horticultural, health and relaxation groups. Patients and staff who met with the inspector reflected positively on the activities available on the ward and the efforts made by OT and nursing staff to ensure the ward's therapeutic activities timetable was delivered. The ward was also equipped with a gym that included a running machine, a sit up machine and an exercise bike. Despite the availability of a number of appropriately trained nursing staff who could supervise patients using the gym, patients were unable to use the running machine and exercise bike as they required repair. A recommendation has been made.

The inspector noted that patient care documentation evidenced patient involvement in their care and treatment. This was supported by nursing staff through daily 1:1 meetings and through patient participation in their weekly team assessment meeting (TAM). The admissions checklist completed with patients evidenced that patients were informed of the availability of 1:1 time with their named nurse and of the purpose of the TAM meetings. The checklist also recorded that patients were given a patient and carer information booklet. The booklet provided a range of information regarding the ward including what patients should expect during their admission. Information regarding patient rights was also available and it was good to note that patient care documentation recorded that staff took time to explain to patients, when required, their rights in accordance to the Mental Health (Northern Ireland) Order 1986.

The inspector reviewed the ward's processes for recording and reporting the use of restrictive practices. Restrictive practices used within the ward included the removal of sharp items, controlled access to the ward, use of observation and use of physical interventions. Records relating to the use of physical interventions were completed on the Trust's MAXIMS system and attached to an incident report prior to being forwarded to the Trust's governance and senior management team. The inspector examined the ward's physical intervention monitoring form, the incident recording records (IR1) and the Trust's observation and engagement policy. The policy and records were noted to be appropriate and in accordance to regional guidance.

The removal of sharp items such as razors and scissors from patients was discussed in the patient and carer information booklet. Care documentation reviewed by the inspector demonstrated that the removal of items from patients had been discussed with each patient and this was reflected in the patient's continuous notes and risk assessment. Patients who met with the inspector reflected that the removal of sharp items was understandable given that the ward cared for people who were unwell.

The ward's main entrance door was locked and access was controlled by ward staff using a key fob and an access control system located in the ward's main office. Patients who met with the inspector confirmed that they could leave the ward upon request providing this had been assessed as appropriate and was in accordance to the patient's risk assessment and their care and treatment needs.

Patient care documentation reviewed by the inspector demonstrated that the use of a restrictive practice had been individually assessed, was proportionate, monitored by the multi-disciplinary team and implemented and completed in accordance to Trust policy and procedure.

The ward's arrangements for discharge were discussed with each patient upon admission. The patient and carer information booklet detailed the arrangements for discharge and the importance of patient and relative/carer involvement in discharge planning. Patient discharge plans reviewed by the inspector evidenced that patient progress and suitability for discharge was reviewed on a daily and weekly basis. It was positive to note that patient discharge plans were supported by community mental health services and the wards social work and occupational therapy staff.

Details of the above findings are included in Appendix 2.

On this occasion the acute ward, Downe Hospital has achieved an overall compliance level of substantially compliant 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	7
Ward Staff	8
Relatives	0
Other Ward Professionals	0
Advocates	1

Patients

Patients who met with the inspector were complimentary regarding the care and treatment they received from staff. One patient expressed dis-satisfaction regarding the reasons why they were in hospital. The patient informed the inspector that they had discussed this with medical and nursing staff and they understood their rights in accordance to the Mental Health (Northern Ireland) Order 1986. Patients' were generally complementary regarding ward staff and the quality of the care and treatment they received comments included:

"Staff treat me alright";

"Cleanliness is second to none…absolutely fabulous";

"All staff are excellent…they always have time for you";

"There is an activities rota…occupational therapy is good";

"Staff are always busy";

Relatives/Carers

No relatives/carers were available to meet with the inspector during the inspection.

Ward Staff

The inspector met with eight members of the ward's multi-disciplinary team (MDT). Nursing staff reported that they felt supported by their line management and they had no concerns regarding their ability to access mandatory training and supervision. The consultant psychiatrist reflected that the MDT was effective, supportive and collaborative. Occupational therapy staff and the ward's social worker reported that they felt their roles were integral to the multi-disciplinary team. Staff comments included:

“I love it here…I am well supported”;

“It’s a good multi-disciplinary team that works”;

“It’s a good team and everyone is listened to”;

“Great bunch of staff always looking out for you”;

“When I first arrived I was made to feel welcome and my induction was at my pace”;

“Excellent ward manager”.

Other Ward Professionals

No other ward staff professionals were available to meet with the inspector during the inspection.

Advocates

The inspector met with one of the ward’s advocate. The advocate informed the inspector that they found the ward staff to be supportive and responsive to the needs of patients. The advocate reflected that they had attended team assessment meetings and they felt the social work support for patients was really good. The advocate reported that they were continuing to work alongside the ward’s staff team to ensure advocacy was fully integrated.

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

Questionnaires issued to	Number issued	Number returned
Ward Staff	20	14
Other Ward Professionals	5	0
Relatives/carers	25	7

Ward Staff

Twelve nursing staff, a doctor and an occupational therapist returned questionnaires prior to the inspection. Nine members of ward staff reported awareness of the deprivation of liberty safeguards and twelve recorded that restrictive practices were used within the ward. Staff listed restrictive practices to include: observations, controlled access to the ward and use of the Mental Health (Northern Ireland) Order 1986. All staff documented that they felt patients on the ward could access therapeutic and recreational activities and activities were designed to meet patient’s individual needs. Additional comments provided on the questionnaires included:
“A very cohesive team within the ward”;

“I feel the Trust will need to provide comprehensive multi-disciplinary training regarding capacity issues as envisaged in the new mental health legislation”.

Other Ward Professionals

No other ward professionals returned questionnaires.

Relatives/carers

Seven questionnaires were returned by relatives prior to the inspection. Three relatives commented that they felt that the treatment of patients on the ward was excellent; three described it as good and one felt that improvements were required. Four of the relatives reported that they had been offered the opportunity to be involved in decisions in relation to the care and treatment of their relative. Three relatives stated that they had not been offered this opportunity. Three relatives recorded that they had been involved in discharge planning, three relatives did not respond to this question and one relative had not been involved in discharge planning. Relative’s comments recorded on the questionnaires included:

“I feel the mental health team do an excellent job caring for my husband”;

“I think the ward is run well and the staff are warm and friendly”;

“Very good”;

“I have mainly been the one to approach staff for feedback at times this has been forthcoming but at times staff didn’t appear to know the current situation regarding specific aspects of my relatives care. Mostly staff have been very good to both of us”;

“I believe my relative is receiving the best care possible and from what I have experienced from very helpful and friendly staff”.

The inspector reviewed the wards procedures and processes for ensuring that relatives were involved in decisions regarding patients. The inspector noted that the ward had introduced performance indicators to monitor staff performance in relation to involving patient’s relatives. It was also good to note that the ward was piloting a ‘think family project’ which is designed to ensure that staff sought and recorded relative’s involvement in patient treatment and care throughout the patient’s admission. These measures were introduced to the ward in August and September 2014 and preceded the issuing of the relatives questionnaires. The inspector was satisfied that the ward had taken appropriate measures to ensure that patient’s relatives were involved in decision making and these measures would address the concerns raised by relatives through the questionnaires.

7.0 Additional matters examined/additional concerns noted

No additional matters were examined/additional concerns noted during the inspection.

Complaints

The inspector reviewed complaints received by the ward between the 1 April 2013 and the 31 March 2014. Seven complaints had been received from service users during this period. Three of the complaints related to concerns about care practice, one related to staff attitude, one relation to food and nutrition and two complaints had been made as a result other concerns. Six of the complaints were recorded as having been resolved to the full or partial satisfaction of the complainant. One complaint had not been resolved and was being managed in accordance to the Trust's complaint procedures.

The inspector found the ward's complaint procedure to be in accordance with the Trust's policy and procedure. The inspector noted that information relating to the complaints procedure was available to patients and their carer/relatives.

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.

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

No.	Reference.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1		It is recommended that all staff have mandatory training and this includes training in protection of vulnerable adults, child protection and care and responsibility	The inspector reviewed the training records for the ward's 28 nursing staff. Training records were maintained on the Trust's electronic roster database. The training database contained the names of all nursing staff and recorded their mandatory training. The inspector noted that all nursing staff had completed mandatory training and that the ward management team had oversight of future training needs. Nurse training records evidenced that 25 staff had completed up to date protection of vulnerable adults training and three staff required refresher training. The inspector noted that staff requiring update training had been booked to attend the next available vulnerable adults refresher course. 27 nursing staff had completed up to date care and responsibility (C&R) training. One member of staff required refresher training. Records evidenced that the staff member had been booked to attend the next available C&R refresher training course. All nursing staff had completed child protection training and a timetable recording future refresher training dates was available. Training records for other professionals within the	Compliant

			multi-disciplinary team were retained by their professional management lead. The inspector met with the ward's occupational therapist, the ward's social worker and the consultant psychiatrist. Staff reported no concerns regarding their ability to complete mandatory training relevant to their role.	
2		It is recommended that all staff sign that they have read and understood policies relating to the protection of vulnerable adults	All nursing staff had completed protection of vulnerable adults (PVA) training which included a review of PVA policy and procedures. The inspector was assured by the ward manager that the PVA policy and procedures had previously been circulated to all staff and staff had been asked to confirm that they had read and understood the policy. Minutes from previous team meetings evidenced that PVA processes remained under continued review. A copy of the regional policy and Trust procedures was available in the ward's main office. Staff who met with the inspector demonstrated appropriate knowledge and understanding of the PVA policy and procedures.	Compliant
3		It is recommended that the ward manager ensures that all staff receive mandatory training	The Trust's electronic roster evidenced that the ward manager had ensured that all nursing staff had received the required mandatory training. Training for other professionals within the multi-disciplinary team was managed by their professional line manager. The inspector was informed by the ward's occupational therapist, social worker and consultant psychiatrist that their required mandatory training had been completed in	Compliant

			accordance to Trust guidelines.	
4		It is recommended that Vulnerable Adult Procedures are included in the corporate induction	The inspector reviewed the Trust's corporate induction programme and noted that the programme included training for staff with regard to the implementation of the Trust's protection of vulnerable adult policy and procedures.	Compliant
5		It is recommended that any records made of a previous referral to the protection of vulnerable adult procedures should provide details of the nature of the referral. In addition, if a protection plan has been put in place previously, this information must also be available to staff currently involved in the patients care and treatment.	The inspector reviewed the ward's vulnerable adult recording and reporting procedures. The inspector noted that vulnerable adult referrals were completed on the Trust's MAXIMS patient information system. The referral was then forwarded to the ward manager and, when required, to the Trust's designated officer (DO) for review. The DO assessed vulnerable adult referrals and forwarded a response to the ward. In circumstances where the DO had provided a protection plan the contents of the plan were agreed with the ward manager and the patient's named nurse, made available on the MAXIMS system and shared with the staff team. All staff on the ward had access to the MAXIMS system.	Compliant
6		It is recommended that any additional assessment of risk (such as a falls risk assessment) are discussed at the next multidisciplinary team meeting. However, if the outcome of assessment identifies that immediate prevention interventions should be put in place such as increasing the level of supervision required then this should be discussed immediately with the consultant and the nurse in charge.	Patient progress on the ward was monitored on a continuing basis by ward staff and reviewed regularly by the multi-disciplinary team during the daily meetings and at the weekly team assessment meeting. Patient care records reviewed by the inspector evidenced that assessment of a patient's care and treatment plan was ongoing and that patient needs were addressed in accordance to identified risks.	Compliant

			Staff who met with the inspector reported that in circumstances where a patient required an increased level of supervision this was discussed with the charge nurse and consultant/medical staff and immediate and appropriate action was then taken.	
7		It is recommended that patients should be involved in the risk assessment or it should be indicated why the patient was unable to sign the documentation.	Upon admission to the ward patients were assessed by a nurse and a doctor. Risk assessments were completed with the patient and recorded on the Trust's MAXIMS patient information system. Patient risk assessments reviewed by the inspector evidenced that patients participated in their assessment and that their opinion and view had been considered. Patient risk assessments updated during admission had not been signed by the patient as these were retained on the MAXIMS system. Patient continuous notes recorded that risk reviews had been completed with the patient.	Compliant
8		It is recommended that relatives should be informed of incidents / accidents with patient consent. Where patient lack capacity the relatives should be informed of all incidents	The inspector examined the ward's incident reporting procedures and reviewed the last ten incidents that had taken place on the ward. The inspector noted that incident recording forms had been completed appropriately. Nine of the incident reports evidenced that the patient's nearest relative had been contacted, with patient consent, and informed of the incident. One incident report recorded that the nearest relative had requested that ward staff not contact them.	Compliant
9		It is recommended that the admission and discharge policy draft is finalised.	The Trust's admission and discharge policy had been approved in September 2013 and is due for	Compliant

			review in September 2015. A copy of the policy was available on the Trust's electronic database which all staff on the ward could access.	
10		It is recommended that the trust develop a policy on restraint in mental health inpatient units.	The Trust had developed a policy for the management of violence and aggression and use of restraint. The policy was implemented in May 2012 and is due for review in September 2015	Compliant
11		It is recommended that other policies requiring renewal, as identified in the report, are updated.	The inspector reviewed the following Trust policies: 1. Policy for the management of violence and aggression and use of restraint; 2. admissions and discharge policy; 3. child visiting policy; 4. observation and engagement policy. Copies of each policy were available on the ward. The inspector noted that three of the policies were up to date and one required review. The observation and engagement policy required review although it had been updated since the completion of the inspection in May 2012. A new recommendation regarding the continual review and updating of all policies relevant to the ward has been made.	Compliant
12		It is recommended that it is recorded when patient property which has been given to staff for safe keeping has been returned.	The inspector reviewed the wards patient property book and noted that patient property given to staff for safe keeping was recorded in the property book and entries included the signatures of two staff. The property book also evidenced when property had been returned to the patient.	Compliant
13		It is recommended that two staff signatures are evident in keeping with the policy when dealing	The ward's patient property book and cash book evidenced that when property or monies were	Compliant

		with patient monies or property	retained by the ward on behalf of a patient two staff signatures had been recorded. The inspector noted that the procedures used by staff were in accordance to Trust policy and procedures.	
14		It is recommended that guidance for staff is reissued regarding safeguarding of patient property and monies	Minutes from ward staff meetings evidenced that the Trust's safeguarding of patient property and monies policy had been reissued to staff. The policy was available on the Trust's shared database which was accessible to all staff. The inspector reviewed the ward's processes for the management of patient's property and noted these to be appropriate and in accordance to the policy and procedures.	Compliant
15		It is recommended that the trust child visiting policy is easily accessible on the ward and that all staff indicate that they have read and understood the policy.	The Trust's child visiting to adult mental health facilities policy was available on the Trust's shared database. All staff on the ward could access the database and a hardcopy of the policy was also available in the main corridor of the ward. Records of ward team meetings reviewed by the inspector evidenced that staff had been requested to read the policy and that childcare issues/concerns remained under continuous review.	Compliant
16		It is recommended that the child visiting policy is displayed for visitors.	The Trust's child visiting to mental health facilities policy was displayed on the ward's main notice board located opposite the ward's central office.	Compliant
17		It is recommended that the area used for children visiting is made child friendly	The inspector reviewed the room used to facilitate child visits to the ward. It was good to note that the room had been extended and was appropriately equipped to meet the needs of children. The room was located away from the main ward, was well lit and spacious and contained a range of children's toys and colouring books.	Compliant

18		It is recommended that patient's do not use the gym until staff have been trained to supervise and induct patients on how to use the equipment safely	The inspector was informed that 12 staff had been trained to supervise and induct patients on how to use the gym equipment. The ward had also introduced guidelines on the use of gym equipment and patient participation in physical activity within mental health services. However, the inspector was informed by staff and patients that the running and cycling machine were broken. A new recommendation regarding the repairing and maintaining of gym equipment has been made.	Compliant

Appendix 1

Follow-up on recommendations made following the patient experience interview inspection on 12 December 2013

No.	Reference.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
19		It is recommended that the ward manager ensures that all patients are informed on admission of the advocacy service on the ward.	Upon admission each patient was given a patient and carer information booklet which included details of the ward's advocacy services. The inspector noted that information regarding advocacy services was available on notice boards located throughout the ward. The inspector met with one of the ward's patient advocates. The advocate reported that they attended the ward on a weekly basis and patients could meet with them as required.	Compliant

Follow-up on recommendations made at the finance inspection on 3 January 2014

No.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
20	It is recommended that the ward manager ensures that a record of the staff member who obtains the key to the drawer where patients' monies are kept, and the reason for access is maintained.	The key to the locked storage where patient's property was kept was retained by the charge nurse. Staff accessing the locked storage area completed a ledger which recorded the name of the staff member and the date, time and reason the storage area was accessed.	Compliant

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
21	SET/5/13	'The Occupational Therapy provision in the Mental Health Inpatient Unit to be asked to reflect on the programmes being delivered to ensure they can appropriately meet the needs of the service users who are currently in hospital'.	The inspector met with the occupational therapy (OT) staff and reviewed the OT programme. The inspector noted that the occupational therapist met with each patient admitted to the ward and completed an assessment of the patient's physical and therapeutic needs. Patients were then offered therapeutic activities in accordance to their assessed needs. The ward's therapeutic activities programme recorded a range of activities available to patients including: relaxation groups, health and wellbeing group, yoga, horticulture, a quiz and creative groups. The occupational therapist also completed 1:1 interventions with patients.	Compliant

22	SET/5/13	All service users and Carers/NOK have the contact numbers of the various community mental health teams and the hours in which they are available, to include the arrangements for accessing mental health services out of hours.	Information regarding community mental health services and accessing services out of hours was given to each patient and their relative upon the patient's discharge. Patient discharge plans reviewed by the inspector recorded that patients were allocated a key worker from their local community mental health team and offered a follow up appointment within seven days of their discharge. The back cover of the patient and carer information booklet provided contact numbers for various voluntary and community support groups. The inspector also noted that the ward's main notice board displayed information regarding the Trust's community mental health services including contact details.	Compliant
23	SET/31/14	Twice weekly on each acute inpatient unit, the Band 6 and Band 7 Ward Sisters/Charge Nurses (B6/B7) will conduct a review of the nursing records of all patients admitted to the unit to ensure compliance with record keeping standards including that all aspects of the care pathway are completed and care plans are not standardised and are person-centred, including care plans for enhanced observations.	A review of the nursing records of all patients admitted to the ward was completed by the ward manager or assistant ward managers within three days of a patient's admission. An audit tool was used to ensure that all aspects of the patient's care pathway were reviewed. The inspector reviewed the audit records of care documentation relating to three patients who had been recently admitted. The inspector noted the audits to be comprehensive and to include comments/recommendations to be followed up by the patient's admitting/named nurse	Compliant
24	SET/31/14	At these twice weekly reviews of records, the B6/B7 will ensure that the agreed proforma has been completed that provides evidence that individual patients, who have been detained, have received a written copy of their rights and	The ward's 'Individual note audit by band 6/7' template included sections to ensure that each patient's file contained evidence that, were required, the patient had been informed of their	Compliant

		have had an opportunity to discuss these with staff.	rights in accordance to the Mental Health (Northern Ireland) Order 1986.	
25	SET/31/14	The formal supervision of staff facilitated by B6/B7 staff will include an audit of the practitioners' records to ensure compliance with best practice.	The mental health programme supervision/workload management template used to record supervision with nursing staff included sections regarding professional development, case work management and the completion of patient record audits. The section in relation to casework evidenced that the band 7/band 6 staff reviewed patient records completed by the practitioner to help ensure continued adherence to best practice guidelines including promoting quality care and child protection guidelines. The template was used to record each nursing staff supervision session and to set agreed actions with specific timelines.	Compliant
26	SET/31/14	NIPEC audits will be conducted monthly to evidence adherence to standards.	The inspector reviewed the ward's NIPEC audit records completed for October 2014. The records recorded that the ward had achieved included the following results: • The patient's care plan is reviewed weekly. Score 96%; • Patients are afforded the opportunity to have 1:1 time with nursing staff in accordance with the ward's standards (20 minutes daily). Score 96%.	Compliant
27	SET/31/14	Following all significant incidents that occur within hospital services, a ward based review will take place the following working day and will include an appraisal of records to ensure that all appropriate documentation has been completed, including that the PQC risk assessments are updated.	A ward based multi-disciplinary team (MDT) "huddle meeting" was conducted every morning. Alongside a review of each patient's progress during the previous day the MDT huddle meeting also considered and reviewed all significant incidents. Reviews of incidents	Compliant

			included appraisal of patient records which were available on the ward's MAXIMS system and accessible to all staff during the huddle meeting.	
28	SET/31/14	At formal supervision with nursing staff and at ward team meetings, B6/B7s will promote carer contact.	The supervision/workload management template used to record nursing staff supervision included review of each practitioner's case work. The casework review encompassed a number of agenda items relevant to the care and treatment of patients which includes family involvement. The ward had commenced a think family project The Think family approach was introduced to the ward to promote increased family input throughout a patient's admission. A pilot project in relation to this family orientated approach commenced on the ward in September 2014 and involves all staff on the ward. Team meeting and team assessment meeting records reviewed by the inspector evidenced that the project remained under continued review and staff were encouraged to promote carer contact and involvement in patient care.	Compliant
29	SET/31/14	Mental Health Hospital Services Manager will implement Key Performance Indicators to review engagement with carers.	The Mental Health Hospital Services Manager had introduced key performance indicators (KPI) to review engagement with carers. The inspector reviewed the KPI's and noted the progress made to include: • The patient's next of kin has been notified of the patient's admission within 24 hours (with patient consent). Score 100%; • There is evidence in the nursing records that staff have engaged with family/carers before and after each	Compliant

			period of patient leave/pass to ensure there is an exchange of information. Score 89%; • There is evidence in the nursing records that the family/carer have been informed of the date and time of the patient's discharge. Score 100%.	
30	SET/31/14	At formal supervision with nursing staff and at ward team meetings, B6/B7s to ensure all staff are familiar with DOLS guidance and ensure that individuals Human Rights are protected.	The supervision/workload management template used to record nursing staff supervision detailed that casework discussions with staff included a review of child protection issues, family support, protection of vulnerable adult issues and risks for patients. Team meeting records reviewed by the inspector revealed that meetings were held on a regular basis. The agenda for the meetings included a review of incidents, discussion regarding complaints received, the think family project and a review of ward procedures including the protection and promotion of patient human rights.	Compliant
31	SET/31/14	The MAXIMS observations window will be reviewed and updated to reflect the description of the levels of enhanced observations in accordance with regional policy.	The inspector reviewed the MAXIMS observations window and noted a section to ensure that the level of enhanced observations used with a patient was clearly stated in accordance to regional use of observation policy.	Compliant
32	SET/31/14	The Trust will explore the potential for introducing technology that will indicate, through an alarm system, that a weight has been applied to an ensuite door.	The inspector was informed by the Mental Health Hospital Services manager/nurse lead that a review of technology for ensuite bathroom doors was progressing and the Trust's estates department were currently sourcing appropriate doors.	Compliant
33	SET/32/14	These ward based incident reviews will include a review of	The inspector reviewed the ward's policy and	Compliant

		the need for completion of Physical Intervention documentation.	procedures in relation to the use of physical interventions with patients. In the event that a physical intervention is required with a patient on the ward an incident report is completed alongside a physical intervention monitoring form. The inspector reviewed records for one incident that required the use of a physical intervention. The records had been completed appropriately and in accordance to Trust policy and procedure. The inspector noted that 28 of the 29 nursing staff had completed up to date care and responsibility training. The remaining member staff had been booked to complete refresher training in the near future.	
34	SET/32/14	At formal supervision with nursing staff and at ward team meetings, B6/B7s will introduce and promote the use of the anti-absconding work book. An audit of all AWOLs to commence reviewing all individual AWOL incidents from 1st May 2014.	An audit of AWOLS that had taken place within acute mental health hospital services had commenced from the 1 May 2014. The Downe Acute ward had experienced four AWOL incidents from the 1 May 2014. The ward manager informed the inspector that the number of AWOL incidents had reduced when compared with the same period from the previous year. The ward manager reported that they felt the introduction of the anti-absconding workbook with all staff had supported the reduction. The inspector reviewed the anti-absconding workbook which was noted to be comprehensive and accredited by City University, London. .	Compliant
35	SET/32/14	Mental Health Hospital Services will link with the Infection Prevention & Control Team to consider the introduction of a 'No Plastic Bags Policy' on all acute inpatient wards.	The Mental Health Hospital Services manager and the ward manager had linked with the Infection Prevention and Control team (IPCT) to consider the introduction of a 'No plastic bags	Compliant

			policy' within the ward. The IPCT had advised the ward manager that the removal of all plastic bags from the ward was not possible due to health and hygiene standards and the requirement of plastic bin liners. However, the ward had introduced a 'bring no plastic bags policy' with patients. Several posters available throughout the ward reminded patients that plastic bags should not be brought to the ward.	

Quality Improvement Plan

Unannounced Inspection

Downe Acute Ward

11 & 12 November 2014

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 mental health hospital services manager 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 the Trust ensures that all policies and procedures relevant to the ward are reviewed and updated in accordance to the previously pre-determined review date.	1	Immediate and ongoing	Mental Health Hospital Services will develop a programme for review of all existing policies, procedures and protocols. All documents due / overdue review will be revised and updated. The Trust aims to have all relevant documents reviewed within 2014 – 15 year.
2	5.3.3(d)	It is recommended that the Trust ensures that gym equipment available for patient use is repaired and maintained to an appropriate standard.	1	31 January 2015	The ward will link with its service users to consult on the purpose of the 'gym' room in order to determine its best therapeutic use. This issue will be included on the agenda of the ward's patient forums during January 2015 in order to reach a decision.
3	6.3.2(f)	It is recommended that the Trust reviews the MAXIMS system and assesses if the system can be used to record patient medical reviews.	1	31 March 2015	The use of MAXIMS as a clinical record in which medical staff will record their notes will be subject to review – with a decision taken by 31.03.2015 as to the feasibility of same.

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	NEIL MORGAN
NAME OF CHIEF EXECUTIVE / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	BRENDAN WHITTLE

Inspector assessment of returned QIP				**Inspector**	**Date**
		Yes	**No**		
A.	Quality Improvement Plan response assessed by inspector as acceptable			Alan Guthrie	**9 January 2015**
B.	Further information requested from provider				

Ward Self-Assessment	
Statement 1: Capacity & Consent • **Patients' capacity to consent to care and treatment is monitored and re-evaluated regularly throughout admission to hospital.** • **Patients are allowed adequate time and resources to optimise their understanding of the implications of their care and treatment.** • **Where a patient has been assessed as not having the capacity to make a decision there are robust arrangements in place in relation to decision making processes that are managed in accordance with DHSSPS guidance.** • **Patients' Article 8 rights to respect for private and family life & Article 14 right to be free from discrimination have been considered**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
• Pre admission to acute mental health wards an individual's capacity and ability to consent is assessed. This assessment is continuously evaluated during the individual's admission and this is evidenced through completion of our inpatient care pathway documentation and also through the regular multi-disciplinary team assessment meetings and documentation. On admission individual patients and their carers are provided with an admission pack which includes the mental health hospital services information booklet, a copy of their rights and expectations of admission and a complaints/suggestions form. Patient information Booklets provides information into services and what is to be expected of their stay in hospital. • Throughout the patients journey they are facilitated with adequate time and resources in the assessment, planning implementing and evaluating of their care. Pre admission and during admission patients and carers are requested to contribute and sign their respective risk assessments. This involvement allows individual patients to be fully informed and be involved in their care. This involvement is further enhanced through patient involvement in their identified needs care planning approach. Care plans are jointly completed with individual patients and carers are also asked to contribute. Individual patients are encouraged to sign their care respective care plans to evidence patient involvement. They are also offered a copy of their individualised care plan.	Substantially Compliant

• Adequate time and resources to understand the implications of their care and treatment can be further evidenced through daily therapeutic interactions with nursing staff, occupational therapy staff and weekly reviews by medical staff. The ward has daily patient care evaluation meetings and the outcomes of these are discussed with patients and their respective carers. • To further enhance understanding of the implications of their care and treatment, the ward has access to an independent advocacy service which is employed by the Trust. The Trust also utilises a team of voluntary Peer Advocates on a weekly basis at ward level. Patients and carers can access these services if requested or if staff. feel that an individual would benefit from accessing these services, they can refer directly to these services. • The ward has commenced completing Key Performance Indicators (KPIs) via a dashboard as evidence of standards of engagement with patient and relatives. • The ward is compliant with The Mental Health Order, rights and powers. Staff have commenced refresher training with regards to the Mental Health Order. • Ward staff are familiar with both Part 2 and Part 4 Doctors as required by the Mental Health with regards to treatments including ECT where individuals are detained for treatment and are deemed not to have capacity to consent. • The Trust has a child visiting policy to facilitate family visiting at ward level. • The ward has created a child friendly visiting area where children and family can visit inpatients. The visiting area is off the main thoroughfare of the ward. This area has a selection of colouring items and toys. • Staff aware of article 8 and Article 14 of the Human Rights legislation. • The ward has been engaging with The Think Family approach which is to increase family input from admission through to discharge. The ward is about are about to commence a pilot in relation to The Think family approach commencing in late September. In accordance with this project our current documentation is being reviewed and tailored to reflect more family focused interventions. Information on specific illnesses for families are available on request.	

• The Trust will be piloting free WI-FI hotspots at ward level for individual services users to have access to services such as Skype and face time to engage with their families. • In light of above Mental Health Hospital Services are developing a new policy on the use of mobile communication devices, which considers individual patient Article 8 rights to respect for private and family and Article 14 rights to be free from discrimination.	
Inspection Findings: FOR RQIA INSPECTORS USE Only	
The inspector reviewed six sets of patient care documentation. Upon admission patients were assessed by a Doctor and a nurse. Medical staff assessed the patient's capacity and completed a mini mental state evaluation as required. Information for patients regarding capacity and decision making was available in the patient and carer information booklet and patients were also supported by two advocacy services that visited the ward each week. In circumstances where a patient had been assessed as lacking the capacity to make decisions regarding their care and treatment staff used the best interest pathway capacity assessment tool to help ensure that decisions were made in the patient's best interest. The tool was also used to ensure that decisions regarding a patient's care and treatment were managed appropriately and in accordance to DHSSPSNI guidelines. At the time of the inspection all patients admitted to the ward had been assessed as having the capacity to make decisions regarding their care and treatment. During the admission process nursing staff completed an admission checklist, a comprehensive nursing assessment, a risk assessment and a care plan. The comprehensive assessment included a review of the patient's mood, perception, thought form and content and cognitive functioning. A care plan was commenced upon arrival and completed within three days of the patient's admission. Patient risk assessments and care plans were retained on the Trusts MAXIMS patient information system. It was good to note that patient information on the MAXIMS system could be accessed by all ward staff and relevant community staff. Copies of documentation were also retained in the patient's hard copy file. Patient progress was regularly monitored by nursing staff, discussed daily at the multi-disciplinary team huddle meeting and reviewed weekly at each patient's team assessment meeting. Patient's continuous records were also retained on the MAXIMS system and the inspector noted that nursing, occupational therapy, social work and community staff provided entries. Patient continuous records evidenced that assessment of a patient's progress, including their capacity to consent to treatment, was reviewed on a regular basis. However, the inspector noted that medical records were completed in handwritten format and retained in the patient's hardcopy file. Subsequently, information relating to patient progress was stored in two separate locations.	Substantially compliant

The inspector discussed this with the ward manager and the mental health hospital services manager. The inspector was informed that the Trust continued to develop the MAXIMS system and it was hoped that medical assessments would be made available on the MAXIMS system in the near future. A recommendation had been made. Consideration of patient's Article eight right to respect for private and family life and Article 14 right to be free from discrimination was evidenced through the ward's arrangements for visitors, the child visiting procedures and the availability of advocacy services. Patients who met with the inspector reported no concerns regarding their family being able to visit the ward. Two patients explained that they felt the ward's visiting arrangements were flexible. It was good to note that the ward had commenced a pilot project designed to increase family involvement in mental health services. The Think family project is designed to monitor and encourage family participation in their relative's admission, treatment and care and discharge from the ward. The pilot project began in September 2014 and involves a review of the ward's interventions with patients with the aim of promoting family focused outcomes. The inspector was informed that the Trust will be commencing the project within the remainder of its mental health acute admission wards in the near future.	

Ward Self-Assessment

Statement 2: Individualised assessment and management of need and risk • **Patients and/or their representatives are involved in holistic needs assessment and in development of related individualised, person-centred care plans and risk management plans** • **Patients with communication needs have their communication needs assessed and there are appropriate arrangements in place to promote the patient's ability to meaningfully engage in the assessment of their needs, planning and agreeing care and treatment plans and in the review of their needs and services.** • **Assessment of need is a continuous process and plans are revised regularly with the involvement of the patient and/or their representative and in accordance with any changes to assessed needs.** • **Patients' Article 8 rights to respect for private and family life have been considered.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
• Pre admission individual patients and carers are encouraged to contribute to their respective Promoting Quality Care risk assessment. On admission patients and their relatives are encouraged to contribute to their identified needs care plans and risk assessment. Care plans are jointly completed with individual patients and carers. Individual patients are encouraged to sign their care respective care plans to evidence patient involvement. They are also offered a copy of their individualised care plan. • Risk assessments are regularly updated at Team Assessment Meetings and care plans are regularly updated in conjunction with individual service users to reflect their changing identified needs. These reviews are evidence through the electronic care recoding system Maxims. From the 1st September the Trust will be commencing the completion of person centred individualised identified care plans on the Maxims system. • Mental Health Hospital services have updated their admission care pathway to reflect information in relation to communication deficits and the need for interpreters highlighted on admission. This information is recorded on the admission care pathway, reflected in their respective care plans and risk assessment.	Substantially Compliant

• The ward has an easy read version of the admission booklet. • Mental health hospital services use signing interpreter services with individuals that have disabilities like hearing difficulties. • The Trust has access to language line and interpreting services to ensure that all individuals with ethnic minorities' backgrounds have access to their first language during the assessment and treatment process within the hospital environment. These actions are completed to ensure that individual patients Article 8 rights are considered.	
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
Patient care documentation reviewed by the inspector included an admissions checklist, a comprehensive medical and nursing assessment, a care plan and continuous patient progress notes. The inspector noted that patient care records completed by nursing staff were retained on the Trust's MAXIMS patient information system. It was positive to note that care plans and risk assessments reviewed by the inspector were comprehensive, patient centred, easy to follow and up to date. Copies of patient care plans had been printed from the MAXIMS system and shared with patients. Patient signatures were available on each of the care plans reviewed. Patients' communication needs were addressed during the patient's initial assessment. The inspector reviewed the Trust's arrangements to support patients requiring communication assistance and noted that the Trust's interpreting service was available twenty four hours a day seven days a week. The patient and carer information booklet included information advising patients that staff would assist them in seeking the help of an interpreter if English was not their first language. It was positive to note that this information was recorded on the first page of the booklet in five different languages. Patient progress was monitored by nursing and medical staff on a daily basis and reviewed by the multidisciplinary team on a weekly basis. The multi-disciplinary team also completed daily patient planning meetings where patient progress and care needs were discussed and reviewed. Patients and staff who met with the inspector reported that communication and relationships within the ward were generally positive. The inspector met with seven patients all of whom reflected an understanding of why they were in hospital. Patients reported that they found staff to be approachable and supportive. It was good to note that the names of each patient's primary nurse were displayed on the noticeboard in the ward's dining area and that patients were invited to attend their weekly multi-disciplinary team assessment meeting.	Compliant

Patients on the ward were also supported by the Trust's community mental health services. The inspector was informed that staff from the Trust's home treatment team attended the ward three times each week. The inspector was also informed that the Trust's psychology services, eating disorder services and the Asperger's specialist link nurse supported patients on the ward as required. Consideration of each patient's Article 8 right to respect for private and family life was evidenced through the information provided to patients upon their admission and through the ward's arrangements for patient's relatives. The patient information booklet discussed visiting times, provided contact information for the advocacy service and relayed what patients should expect from staff. Patients who met with the inspector reported no concerns regarding their ability to meet with their relatives.	

Ward Self-Assessment	
Statement 3: Therapeutic & recreational activity • **Patients have the opportunity to be involved in agreeing to and participating in therapeutic and recreational activity programmes relevant to their identified needs. This includes access to off the ward activities.** • **Patients' Article 8 rights to respect for private and family life have been considered.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
Daily meaningful activities are facilitated and therapeutic programmes are available to all patients on the ward; tailored individualised OT input is discussed at the weekly Team Assessment meeting. Some of the available therapeutic activities include: the horticultural project within the ward garden area, recovery focussed groups, gender specific groups, a weekly music session, twice weekly outings (walking and social) and a twice monthly social evening by the patients. There are two computers within the OT group room for patients to avail of so to have contact with family/friends via social media and to use as a means for their recovery journey (i.e. searching for housing, volunteering opportunities). The weekly patient forum provides discussion in relation to relevant therapeutic activities their interests and what groups/sessions the patients would like to have on the ward. Weekly therapeutic programmes are available and on display outside the OT room and in the communal area. Our OT and OTA engage patients in discussion regarding their occupational interests during the OT initial interview and use this information to guide engagement within the therapeutic process, throughout the inpatient stay. There is access to the OT facilities during the evening. The family area has a selection of drawing and toys available for use. We have seasonal events such as Easter/ Summer BBQ/Halloween/Christmas Parties We refer people into Men's Shed and New Horizons Evening and weekend activities are carried out by ward staff.	**Compliant**

Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
The ward's multi-disciplinary team included a full-time occupational therapist (OT) and an OT assistant. The ward had a large well equipped OT room, a patient kitchen and a life skills room which was equipped with a washing machine and dryer for patient use. The OT room contained a wide variety of art and craft materials, two computers and a selection of board games. Activities were provided on a daily basis and included creative, horticultural, health and relaxation groups. Patients and staff who met with the inspector reflected positively on the activities available on the ward and the efforts made by OT and nursing staff to ensure the ward's therapeutic activities timetable was delivered. The ward provided a small fitness room that included a running machine and an exercise bike. The inspector was informed that the ward had a number of appropriately trained nursing staff who could facilitate patient use of the equipment and that patients wishing to use the exercise equipment completed a medical assessment prior to commencing an exercise programme. The ward manager explained that the equipment was currently not being used as it was broken. A recommendation has been made. Activities provided by the nursing staff were also available. The ward's record of nurse lead activities evidenced that during the first two weeks of November 2014 nursing staff had facilitated a recovery group, a number of walks, card games and a hand care session. The inspector noted that the activities provided were designed to include all patients. Patients who met with the inspector reflected that they enjoyed the ward activities. Not all patients chose to use the ward's occupational therapy room and it was positive to note that nursing staff opened the room during the evenings and at weekends to facilitate patient use of the computers and art materials. Patient's Article eight right to respect for private and family life had been considered with regard to the provision of therapeutic and recreational activities. This was evidenced through the provision of a range of individual and group activities which patients could choose to attend and the availability of OT and social work support. Visiting times with family or friends were protected and flexible and not negatively impacted on as a result of the therapeutic and activity programmes. Visits from patient's children/grandchildren could also be facilitated in a separate visiting room located outside the main ward area. The room had been extended and was equipped with children's toys and books.	Substantially compliant

Ward Self-Assessment

Statement 4: Information about rights • **Patients have been informed about their rights in a format suitable to their individual needs and access to the communication method of his/her choice. This includes the right to refuse care and treatment, information in relation to detention processes, information about the Mental Health Review Tribunal, referral to the Mental Health Review Tribunal, making a complaint, and access to independent advocacy services.** • **Patients' Article 5 rights to liberty and security of person, Article 8 rights to respect for private and family life and Article 14 right to be free from discrimination have been considered.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
• Mental Health Hospital Services have recently updated their nursing admission care pathway to ensure that all individual patients and their carer's are advised of Trust policies on relation to entry and exit, 30 minutes checks and observation and engagement. • On admission all individuals and carers are advised of their rights and expectations of admission. This information is also explained through the admission information booklet. Patient responsibilities are highlighted on the nursing admission care pathway. • All detained patients are advised initially advised on admission of their status as reflected in the admission care pathway. • They are also explained both verbally and in writing, Leaflet 2 and Leaflet 6 which reflects their legal rights of appeal to the Mental Health Review Tribunal. Signed confirmation of this is recorded in individual notes and if declined there is signed confirmation by 2 members of nursing staff. Mental health tribunal application forms are also provided at this stage. • All patients are advised of access to advocacy services. This is evidenced in the nursing admission care pathway. • The ward also provided a carer advocacy service on a weekly basis on a Monday evenings	**Compliant**

Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
Patients who met with the inspector explained that they knew why they were in hospital. Six patients reported that they understood what the advocacy service was and that they could meet with the advocate as required. One patient explained that they did not know what the advocacy service was although they recognised who the advocate was and reported that they could meet with the advocate as required. The ward's admission checklist prompted staff to ensure that each patient on the ward had been made aware of their rights. This included patient rights in accordance to the use of the Mental Health (Northern Ireland) Order 1986 (the Order). The patient and carer information booklet detailed information in relation to what a patient should expect regarding their care and treatment, the responsibilities of the ward staff team, discharge planning and information regarding the advocacy service and the Trust's complaints and compliments procedure. Patients admitted to the ward in accordance to the Order were provided with verbal and written explanation regarding their rights under the order. This included the right to challenge their admission to hospital through the mental health review tribunal. Information regarding detention processes, the mental health review tribunal, making a complaint, and access to independent advocacy services was also available on the ward's notice boards. The inspector met with one of the ward's advocates. The advocate explained that they attended the ward each week and could be contacted by patients as required. The advocate reported that they found the ward manager and staff team supportive and responsive to requests from patients. The notice boards opposite the patient's dining room and in the ward's main hall displayed a wide variety of information relevant to patients. The information available included a list of each patient's named nurse for the day, the ward's therapeutic activities schedule, the Trust's complaints procedure and information relating to voluntary, community and carer/relative support groups. Seven questionnaires returned to RQIA by relatives/carers reflected that relatives valued the care and treatment given to patients and that ward staff promoted and encouraged family/carer involvement. Information provided to patients admitted to the ward demonstrated that consideration had been given to patient's Article 5 right to liberty and security of person, Article 8 right to respect of private and family life and Article 14 right to be free from discrimination. Patient care documentation reviewed by the inspector evidenced that staff continued to review patient care and treatment plans in accordance to the patient's best interests and with respect to their rights. Patients were also able to avail of other rights safeguards including the patient's forum /staff meetings and through the availability of independent advocate services.	Compliant

Ward Self-Assessment

Statement 5: Restriction and Deprivation of Liberty • **Patients do not experience "blanket" restrictions or deprivation of liberty.** • **Any use of restrictive practice is individually assessed with a clearly recorded rationale for the use of and level of restriction.** • **Any restrictive practice is used as a last resort, proportionate to the level of assessed risk and is the least restrictive measure required to keep patients and/or others safe.** • **Any use of restrictive practice and the need for and appropriateness of the restriction is regularly reviewed.** • **Patients' Article 3 rights to be free from torture, inhuman or degrading treatment or punishment, Article 5 rights to liberty and security of person, Article 8 rights to respect for private & family life and Article 14 right to be free from discrimination have been considered.**	**COMPLIANCE LEVEL**
• Mental health hospital services provided a person centred individualised care, to ensure that individual patients do not experience blanket restrictions or deprivations of liberty. • Deprivation of liberty standards are displayed on the ward and have been discussed at ward meetings. • The trust has a specific observation and engagement policy which staff, including temporary staff read and sign the competency check list to ensure that individuals are not exposed to blanket restrictions and inappropriate deprivations of liberty • Enhanced observations are explained to all patients and evidenced through the nursing admission care pathway and individualised care planning. • Potential restrictive practises are considered in relation to the observation policy. • Care planning and risk assessment in relation to enhanced observations are reviewed on a daily basis with the multi-disciplinary team. • Potential restrictive practises are considered in relation to the observation policy. Care planning and risk assessment in relation to enhanced observations are reviewed on a daily basis with the multi-	**Substantially Compliant**

disciplinary team. • Potential restrictive episodes should be recorded on the Trusts IR1 incident recording system which is scrutinised by the management team of the ward and then it is subject to further scurrility by the hospital co-ordinator. This offers an assurance that blanket bans/restrictive practises are not happening.	
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
Patients who met with the inspector stated that items including razors and lighters had been removed from them upon admission. Patients reported that they had understood why these items had been removed and that they could access the items upon request providing this was assessed as being in accordance to their care and treatment needs. The removal of sharp items such as razors and scissors from patients was discussed in the patient and carer information booklet. Care documentation reviewed by the inspector demonstrated that the removal of items from patients had been discussed with each patient and this was reflected in the patient's continuous notes and risk assessment. The ward's main entrance door was locked and access was controlled by ward staff using a key fob and an access control system located in the ward's main office. Patients who met with the inspector confirmed that they could leave the ward upon request providing this had been assessed as appropriate and was in accordance to the patient's risk assessment and their care and treatment needs. The patient and carer information booklet detailed that the entrance to the ward was controlled and that should a patient wish to exit the ward a member of nursing staff would be available to support them. During the inspection the inspector noted that a number of patients left and returned to the ward on a regular basis. The ward manager informed the inspector that the ward promoted patients taking time away from the ward as part of their recovery plan and programme. Care documentation reviewed by the inspector recorded that the use of time away from the ward had been discussed with the patient, agreed by the multi-disciplinary team and was reflected in the patient's risk assessment, care plan and continuous notes. The inspector reviewed the ward's processes for recording and reporting the use of physical intervention. Records relating to the use of restraint were completed on the Trust's MAXIMS system and attached to an incident report prior to being forwarded to the Trust's governance and senior management team. One patient who met with the inspector reported that they had experienced a physical intervention by staff. The patient informed the inspector that they had not been hurt during this and that staff had reassured them and explained why the intervention was being used. The inspector examined the ward's physical intervention monitoring form, the incident recording records (IR1) and the Trust's observation and engagement policy. The policy and records were appropriate and in accordance to regional guidance.	Compliant

The inspector noted that patients' article three right to be free from torture, article five right to liberty and security of person, article eight right to a private and family life and article 14 right to be free from discrimination had been considered. This was evidenced through entries in patient care documentation and through the management and use of restrictive practices with individual patients. Patient care documentation reviewed by the inspector demonstrated that the use of restrictive practice had been individually assessed, was proportionate, monitored by the multi-disciplinary team and implemented and completed in accordance to Trust policy and procedure. The ward's complaints procedures, patient/ staff meeting and the availability of the ward's advocates provided patients with additional safeguards and helped to ensure that each patient had appropriate opportunity to express their opinions and concerns.	

Ward Self-Assessment

Statement 6: Discharge planning • **Patients and/or their representatives are involved in discharge planning at the earliest opportunity.** • **Patients are discharged home with appropriate support or to an appropriate community setting within seven days of the patient being assessed as medically fit for discharge.** • **Delayed discharges are reported to the Health and Social Care Board.** • **Patients' Article 8 rights to respect for private and family life have been considered.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
• Mental health hospital services, encourages family's to be involved in the discharge of their loved ones at the earliest opportunities. This will be evidenced through the carers contacts recorded on Maxims, on-going work with Key performance indicators and also with the implementation of the Think Family project at ward level. There is further evidence of family involvement on Team assessment meetings documentation. • All individuals who are discharged from hospital will have a seven day follow up with an appropriate service. • Delayed discharges are reported on a monthly basis through PMSID. • The Trust has also developed an internal reporting mechanism for delayed discharges to ensure that those delayed discharges are appropriately and speedily placed in an appropriate placement. This is in consideration of the Article 8 rights for private and family life	**Substantially Compliant**
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
The patient and carer information booklet included a section describing the arrangements for patient discharge. The section included a statement detailing that staff valued working with the patient and their relative/carer to prevent a long admission and to working towards the patient returning home as soon as possible. The ward's patient admission checklist evidenced that discharge planning was discussed with patients and their relatives/carers upon their admission. Patients who met with the inspector reported that they could meet with nursing staff as required and that they had ongoing weekly contact with their consultant. Each of the patients	Compliant

reflected that they had been involved in their treatment and care and that discharge planning had been discussed with them. Discharge planning for each patient was also reviewed and discussed at the patient's weekly team assessment meeting (TAM). Patients could attend the TAM meeting upon request and TAM records reviewed by the inspector evidenced that a patient's discharge plan was continually updated. Patient progress including their discharge plan was also reviewed daily at the multi-disciplinary team huddle meeting. The inspector noted that the patient's Article 8 rights to respect for private and family life had been considered. This was evidenced through the patient's right to attend their weekly care plan review which included discussions regarding the patients discharge. Patients and staff who met with the inspector reflected that the involvement of relatives/carer in the care and treatment of patients was promoted and enabled throughout the patient's admission. The mental health hospital services manager had introduced key performance indicators (KPI) in relation to engagement with relatives/carers. KPI records revealed that the ward had achieved 100% when ensuring that a patient's relative/carer had been informed of the date and time of the patient's discharge. It was positive to note that the ward operated flexible visiting hours and that there was good provision to enable children and young people to visit the ward. The inspector was informed that one patient's discharge had been delayed and this has been recorded in accordance to the Health and Social Care Board. The patient was awaiting the provision of appropriate accommodation to ensure that their care needs were fully met.	

Ward Manager's overall assessment of the ward's compliance level against the statements assessed	COMPLIANCE LEVEL
	Substantially Compliant

Inspector's overall assessment of the ward's compliance level against the statements assessed	COMPLIANCE LEVEL
	Substantially compliant