The Regulation and Quality Improvement Authority

RQIA

Mental Health and Learning Disability

Unannounced Inspection

Downe Dementia Ward, Downe Hospital

South Eastern Health and Social Care Trust

22 and 23 January 2015

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Contents

1.0 General Information

Ward Name	Downe Dementia Ward
Trust	South Eastern Health and Social Care Trust
Hospital Address	2 Struell Wells Downpatrick BT30 6RL
Ward Telephone number	028 4483 8254 / 028 4483 8260
Ward Manager	Paula Thompson
Email address	paula.thompson@setrust.hscni.net
Person in charge on day of inspection	Barry Lynch
Category of Care	Dementia Care
Date of last inspection and inspection type	18 June 2014, patient experience interview inspection
Name of inspector(s)	Alan Guthrie

2.0 Ward profile

The Downe Dementia assessment and treatment unit is a twenty bedded mixed gender ward. The ward provides care and treatment to patients suffering from dementia. The main entrance doors to the ward are locked and access is gained by use of a swipe care or by ringing the doorbell.

Patients are admitted to the ward for a period of assessment, usually 8 – 12 weeks. During the inspection the ward was supported by a multi-disciplinary team including; a consultant psychiatrist, psychiatric and general medical staff, nursing staff, occupational therapy staff and social work staff. There were 14 patients admitted to the ward. Five patients had been admitted in accordance to the Mental Health (Northern Ireland) Order 1986.

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 Dementia Ward was undertaken on 22 and 23 January 2015.

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

The recommendations made following the last unannounced inspection on 12 March 2014 were evaluated. The inspector was pleased to note that 19 recommendations had been fully met and compliance had been achieved in the following areas:

- the ward's policies had been reviewed and updated;
- the ward's fire doors were not being propped or wedged open and a risk assessment for storage of fire extinguishers had been completed;
- information in relation to access to information had been communicated to relatives and an a patient application form to request access to records was available;
- the policy and procedure in relation to the handling of patients' monies had been updated;
- the ward's laundry service had been reviewed and patients clothing was being marked with a number specific to each patient. This ensured confidentiality and reduced the risk of items being lost or misplaced;
- vulnerable adult referrals generated by the ward were being managed in accordance with regional and Trust policy;
- quarterly governance reports detailing the frequency and type of incidents occurring on the ward were provided to the ward staff and the senior management team;
- patient and ward bathrooms had been fitted with appropriate storage and towel rails had been ordered and were due to be fitted shortly;
- the ward's assistive technology devices had been reviewed and a new system had been ordered;
- fire doors to patient dining areas had been fitted with magnetic catches to ensure continued patient access and fire safety;
- the shutter between the kitchen area and the dining room in the ward's six bedded annex had been repaired and was working properly;
- patients on the ward could access a physiotherapist;
- access to the ward's IT system was secure;
- the ward's gardens had been cleaned and appropriately maintained.

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

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

The recommendations made following the finance inspection on 3 January 2014 were evaluated. The inspector was pleased to note that all of the recommendations had been fully met and compliance had been achieved in the following areas:

- all items brought into the ward by patients were recorded, with appropriate completion of records and receipting;
- accurate records of patient monies were being maintained in partnership with the Trust's finance department;
- clear and accurate records of withdrawals made from the cash office by patients or staff were being maintained;
- individual statements regarding patient's finances held by the Trust were being received from the Trust's cash office;
- the Trust's policy for management of patients' finances had been updated and shared with staff.

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 environmental changes, improving records about the care and treatment patients receive, reviewing the ward's laundry services and ensuring that patients can access a physiotherapist as required.

The following is a summary of the inspection findings in relation to the Human Rights indicator of Autonomy and represents the position on the ward on the days of the inspection.

The inspector reviewed four sets of patient care documentation. Patient records evidenced that each patient's capacity to consent to their care and treatment was reviewed daily by nursing staff and weekly basis by the ward's multi-disciplinary team. Care records demonstrated that decisions made on behalf of a patient were done so in the patient's best interests and in consultation with the patient and their relative. Patient's progress notes and the multi-disciplinary team meeting records evidenced that decisions made on behalf of a patient were completed in accordance to DHSSPSNI guidelines. Staff who met with the inspector reported that they felt the ward's procedures for supporting patients who lacked capacity were appropriate and patient centred. Relatives who spoke with or contacted the inspector reflected that their experiences of the ward had been "excellent" and they felt they had been given the opportunity to be involved in decisions regarding patient care.

Care records reviewed by the inspector were noted to be comprehensive, individualised and person centred. Upon admission patients were assessed by a doctor and a nurse prior to the completion of a care and treatment plan. Care plans reviewed by the inspector were noted to be specific to the individual needs of the patient. However, two of the care plans had not been

signed by the patient, or their representative, and there was no record detailing if the patient had been unable to sign. A previous recommendation regarding care documentation has been restated.

Patient assessments included a review of the patient's physical health needs and identification of any presenting risk in relation to nutrition, falls or pressure ulcers. The inspector noted that these assessments had been completed for each patient. However, the falls risk care pathway adjoining the falls risk assessment had not been completed in any of the patient care records reviewed. Also, the malnutrition (MUST) and pressure ulcer (Braden scale) assessments had not been completed in accordance to the identified review timescales. The inspector was informed that the falls care pathway was not required as the management of risk in relation to a patient falling was recorded in the patient's care plan. The inspector was concerned that the falls care pathway formed part of the assessment of a patient's status and this informed the care planning for the patient. A recommendation that a falls care pathway is completed as required has been made.

The Braden scale stipulates that a patient's risk status should be re-evaluated on a weekly basis in an acute care setting and on a monthly basis in long term care settings. The inspector discussed the use of the Braden scale with nursing staff. Staff reported that the frequency of reviews as identified on the Braden scale was not proportionate to the needs of all patients on the ward as some of the patients were receiving long term care. A recommendation that the Trust reviews the Braden scale and ensures that it is used in accordance to each patient's assessed need has been made. The MUST screening tool records that a patient should be reassessed weekly. Care records reviewed by the inspector evidenced that patients were being assessed however; assessments were not being completed on a weekly basis. A recommendation has been made.

The ward provided a range of therapeutic and recreational activities which were facilitated by the ward's occupational therapists (OT), ward staff and community organisations. Patients could access an exercise group, a newspaper group, a reminiscence group, communication group and a practical group (arts/crafts/cooking/interests group). Patient care records reviewed by the inspector reflected that each patient's individual activity preferences had been considered. The inspector also noted that patient involvement in activities was recorded in the patient's progress notes. The ward invited a musician to visit every Friday to play guitar and the wards piano and to host sing a longs. Patients could access the ward's garden areas as required and the ward was supported by a community based gardening group during the spring and summer months. It was positive to note that patient's relatives could visit the ward daily from 10 am to 8pm. During the inspection the inspector noted that relatives were on the ward throughout the day. The inspector was informed that patients regularly left the ward with their relatives to go for walks or to attend the café located upstairs in the general hospital. Ward staff could also access a minibus as required and this was used to facilitate shopping trips and outings.

Patients on the ward could access speech and language therapy, social work support, psychology, podiatry, dietetics and physiotherapy services as required. The ward's social workers and occupational therapists provided community support and liaison to assist patients with their discharge from the ward and resettlement back into the community. It was positive to note that the ward had completed a patient resettlement project with residential and nursing care providers.

The ward provided a comprehensive range of information for patients and relatives. A ward information folder was available in each patient's bedroom. The folder provided patients with details regarding the ward's ethos, routine, the roles of staff and contact information for each of the consultant psychiatrists. The folder also contained a statement encouraging patients and relatives to discuss any concerns they might have with the patient's primary nurse or the ward manager. The ward's notice boards were well presented and contained information that was up to date and relevant to patients and their families. It was good to note that one of the notice boards recorded that the ward's advocate attended the ward each Monday, and as required, to provide patients and their relatives with support. Relatives who contacted the inspector reported no concerns regarding their ability to access information.

The ward's main entrance doors were locked and access/exit could be gained through the use of a swipe card or via a buzzer system. Having met with several patients, and completed a review of the assessment information available in four sets of patient care records, the inspector noted that the use of a locked door was appropriate to ensuring the safety and wellbeing of patients on the days of the inspection. Care records evidenced that a locked door care plan had been completed for each patient. However, locked door plans reviewed by the inspector had not considered the individual needs of each patient and lacked a rationale as to why the patient required the use of a locked door. A recommendation has been made. The inspector was informed that patients could leave the ward as required provided this was in accordance to their care and treatment plan.

The inspector reviewed the ward's processes for the management of continuous/enhanced observations. The inspector noted that one patient was receiving enhanced observations during the inspection. The patient's care records evidenced that the use of observations had been agreed by medical and nursing staff and observations were being managed in accordance to Trust policy and procedure. This included daily review of the patient's progress and reassessment of the need for continued enhanced observations.

Ward staff informed the inspector that the use of a physical intervention with a patient occurred occasionally within the ward. The inspector reviewed the ward's procedures for the management of physical intervention and noted this to be in accordance to Trust policy. Staff who met with the inspector demonstrated appropriate knowledge and understanding of the ward's procedures for the management of patients requiring a physical intervention. Nursing staff training records reviewed by the inspector evidenced that 19 of the ward's 26 nursing staff had completed up to date managing aggression

training and seven staff members required further refresher training. Training records also evidenced that a number of nursing staff had not completed all of their required refresher training. The inspector recorded staff training deficits in relation to infection control, basic life support, ulcer pressure care and manual handling. A recommendation has been made.

Each patient's discharge from the ward was discussed with the patient and their relative on the patient's admission. This was evidenced through the completion of the ward's admission checklist and by the provision of a patient information folder. A patient's discharge from the ward was supported by the ward's multi-disciplinary team in partnership with Trust community teams and residential and nursing care providers. It was positive to note that the ward had recently completed a pilot outreach project offering support to patients through developing partnerships with staff from residential and nursing homes. The project involved staff from residential and nursing home providers meeting and working with ward staff prior to the patient's discharge from the ward. This allowed the residential/nursing staff to get to know the patient and helped to support a smoother transition and discharge for the patient. The ward had also completed a new discharge protocol which would be implemented in the near future.

Details of the above findings are included in Appendix 2.

On this occasion Downe Dementia 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	5
Ward Staff	9
Relatives	1
Other Ward Professionals	0
Advocates	0

Patients

Patients who met with the inspector reported no concerns regarding the treatment and care they received on the ward. Patients presented as relaxed and at ease in their surroundings. Patients moved freely throughout the ward and interactions between patients and staff were noted to be positive, friendly and supportive. Patient comments included:

“Staff are all right”;

“Staff do the best they can”;

“It’s a nice place”;

“You get the best of everything here”.

Relatives/Carers

The inspector met with one relative during the inspection. The relative reflected positively on their experience of the ward and the care and treatment the patient had received. The relative’s comments included:

“Very positive experience”;

“The staff are very good at keeping me informed”;

“The admission process was managed well”;

“I have seen a great improvement with my relative”;

“Staff are very caring and honest”;

“I can attend the team assessment meeting as required”;

“There is so little help in the community …as a relative it is very lonely in the community”.

Ward Staff

The inspector met with eight members of the ward’s multi-disciplinary team (MDT). Nursing staff reported that they felt supported within the ward and they had no concerns regarding their ability to access supervision. A doctor reflected that the ward team was effective and patient focussed. The ward’s occupational therapist and the ward’s social worker reported that they felt their roles were valued by the MDT and their service was an integral part of the team. Staff comments included:

“Wards really well run”;

“I feel very supported”;

“Its fine …good systems”;

“I am listened to and my opinion is considered”;

“It’s the best is ever been”;

“Great ward…great team”;

“Nurse led decisions and nurse insights are very valuable”.

Other Ward Professionals

No other ward professionals were available to meet with the inspector on the day of the inspection.

Advocates

No advocates were available to meet with the inspector on the day of the inspection.

Questionnaires

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

Questionnaires issued to	Number issued	Number returned
Ward Staff	20	0
Other Ward Professionals	5	0
Relatives/carers	15	4

Ward Staff

No questionnaires were received from ward staff prior to the inspection

Other Ward Professionals

No questionnaires were received from other ward professionals prior to the inspection

Relatives/carers

Four questionnaires were returned by relatives prior to the inspection. Each of the relatives commented that they felt the patient had received "excellent" care during their admission. Relatives reported that they had been offered the opportunity to be involved in decisions in relation to the care and treatment of the patient. All of the relatives recorded that the patient had received information regarding their rights in a format appropriate to the patient's communication needs. Relative's comments recorded on the questionnaires included:

"My relative is receiving excellent care in the hospital. The staff are very friendly and provide excellent nursing care. They inform us of any change in my relative's condition and always take time to talk to us when we visit";

"The staff are very caring and excellent at communicating with the patient at their (patients) level. They are very attentive and willing to discuss the family's concerns…we are very happy with the care our relative has received".

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. One complaint had been received from a relative in relational to care practice, staff attitude and environmental issues. The compliant had been addressed to the full satisfaction of the complainant.

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.

Appendix 1 – Follow up on Previous Recommendations

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

Appendix 2 – Inspection Findings

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

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

Appendix 1

1. Follow-up on recommendations restated from the inspection completed on the 17 January 2011

No.	Reference.	Recommendations	Number of times stated	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1		It is recommended that a review is carried out of the wards' policies to ensure that they are up to date and easily accessible for staff to view. Policies and procedures should be subject to a defined systematic and timely review, at a minimum of at least once every three years.	3	The inspector reviewed a number of the Trust's policies relevant to the ward. This included policies regarding the handling of patient's cash and valuables, the observation and engagement policy, the fire safety policy, the entry and exit policy for acute inpatient units, the admission and discharge policy and the child visiting policy. The inspector evidenced that the handling of patient's cash and valuables, the fire safety policy and the admission and discharge policy were up to date. The child visiting policy and entry and exit to acute ward policy were being updated as these required reviews in December 2014. The observation and engagement policy had not been reviewed from April 2014. However, the inspector noted that the Trust had commissioned a patient observation and engagement working group. The group was reviewing the Trust's policies and procedures for managing enhanced/continuous observations. The terms of reference for the group included the publication of revised policy and procedures by January 2015. The Trust had taken the decision to postpone the review of its original observation and engagement policy and await the findings from the observation working group. This decision had been shared with ward staff.	Fully Met
2		It is recommended that the Ward manager takes precautions against the risk of fire by ensuring the following: • Fire doors are not	3	The inspector reviewed all of the ward's fire doors and noted that none of the doors had been propped open. The ward had been equipped with two magnetic door release systems which enabled patients and staff to move freely between the ward's main corridors and the two dining areas without having to open and close the fire doors.	Fully Met

		propped or wedged open at any time • A risk assessment is completed for storage of fire extinguishers in the event that they need to be removed from their allocated point on the ward.		The Trust's fire officer had completed a risk assessment regarding the storage of fire extinguishers. Fire extinguishers had been relocated to positions where they did not pose a risk to patients or staff and where they remained accessible to staff in the event of a fire. Signs detailing the location of the fire extinguishers were posted in the ward's reception area and nursing station.	

2. Recommendations restated from the inspection completed on the 21 February 2012

No.	Reference.	Recommendations	Number of times stated	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
3		It is recommended the Ward Manager audits training records to identify gaps in knowledge and skills and ensure attendance at required training.	2	The inspector reviewed the ward's staff training records for 26 members of the nursing staff team. The records evidenced the names of staff who had completed refresher training and the dates to which the training would remain valid. However, the training records were incomplete as the inspector was unable to identify the names of staff members who and not completed training. Subsequently, the inspector could not assess the training records for all nursing staff providing care and treatment to patients on the ward. From the training information available the inspector noted training deficits in relation to: • 13 staff (50%) had not completed up to date training in basic life support; • nine staff (37%) had not completed up to date infection control training; • 16 staff (62%) had not completed up to date pressure ulcer prevention training; • nine staff (37%) had not completed up to date manual handling training; • 23 staff (88%) had completed the required C&R (physical intervention) training. The inspector was concerned that given the presenting needs of the patient group, the records of training were insufficient to assure the Trust that staff had the necessary updated skills and knowledge to fulfil their roles and responsibilities.	Not Met
4		It is recommended that the	2	Relatives could access information within the patient	Fully Met

		ward manager ensures that information in relation to access to information is communicated to relatives.		information booklet and on notice boards located in the corridor leading from the ward's main entrance. It was good to note that the information available was comprehensive and provided relatives with an overview of the ward's procedures and processes. The notice boards also posted contact details for advocacy services, displayed pictures of the ward staff, explained the ward's laundry service and provided blank copies of a relative's questionnaire requesting relative's view's regarding the quality of the care and treatment provided to patients on the ward. One notice board also displayed an application for access to health and social care records. The application detailed a patient's right to apply to access information held about them by the Trust and the patient's right to designate their relative to act on the patient's behalf.	
5		It is recommended that the ward manager reviews and updates the policy and procedure in relation to the handling of patients' monies.	2	The inspector reviewed the ward's policies and procedures in relation to the handling of patient's monies. The Trust's handling of patient's cash and valuables policy had been reviewed and was up to date. The ward's procedures for handling patient's monies were noted to be appropriate and in accordance to Trust and regional guidance. The ward retained two receipt books. One book was used to record patient's money upon the patient's admission and prior to the money being deposited to the Trust's cashier office located in the adjoining general hospital. The inspector noted that the cashier office returned a receipt of lodgement which contained the patient's Trust account details. Records reviewed by the inspector evidenced that the cashiers' receipt was stapled to the original receipt completed by ward staff. The second cash book was used to record cash withdrawn	Fully Met

				from the cashiers' office. The book contained a receipt of the amount withdrawn and a cashier's receipt confirming the withdrawal. Both books were double signed by staff. The ward manager completed a monthly finance audit which included scrutiny of the ward's deposit and withdrawal books.	
6		It is recommended that the systems in relation to the identification and laundering of clothing are reviewed to ensure patients clothing is kept safe and there are no unnecessary delays when clothing leaves the ward to be individually marked, or laundered.	2	A review of the systems in relation to the identification and laundering of patient's clothing had been completed. Upon admission patient's clothing was recorded in the patient's property book and forwarded to the hospital's sewing room. The patient's clothing was then marked with a number to distinguish it and to assure confidentiality. Patient's clothing not laundered by a patient's relative/carer was sent to the Ulster hospital to be laundered, forwarded to the Lagan Valley hospital to be ironed prior to being transported back to the ward. Patient's clothing laundered by the patient's relative/carer was collected by ward staff and stored in a laundry bang in the patient's pigeon hole located in one of the ward's side rooms. Relatives/carers could collect the laundry bag as required. Relatives who spoke with/contacted the inspector reported no concerns regarding the arrangements for the laundering of patient's clothing.	Fully Met

3. Recommendations made following the inspection on the 12 March 2014

No.	Reference.	Recommendations	Number of times stated	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
7		It is recommended that the ward manager ensures that all assessment and care documentation is completed in accordance with Trust and clinical standards.	1	The inspector reviewed four sets of patient care documentation. Each patient had received an assessment, a risk assessment, a care plan and continuous review of their progress. Care records were noted to be up to date and comprehensive. However, two of the patient care plans reviewed by the inspector had not been signed by the patient and there was no entry to explain if the patient had been unable to sign. This recommendation will be restated for a second time in the quality improvement accompanying this report.	Not met
8		It is recommended that the ward's designated officer ensures that vulnerable adult referrals generated by the ward are managed in accordance with regional and Trust policy.	1	The inspector reviewed the ward's processes for the completion and management of vulnerable adult (VA) referrals. Staff who met with the inspector demonstrated appropriate understanding of the process and reported no concerns regarding the support they received from the ward's designated officer. The inspector met with the ward's investigating officer (IO). The IO explained that all vulnerable adult referrals were managed in accordance to regional guidance and a record of referrals was maintained and shared with ward staff. Vulnerable adult referrals reviewed by the inspector had been completed in accordance to policy and procedure.	Fully Met
9		It is recommended that the Trust's governance department provides quarterly returns to the ward detailing frequency and type of incidents occurring.	1	The operations manager informed the inspector that all incident reports were reviewed by them. The manager explained that the ward prepared a monthly governance report which included a record and review of all incidents. The governance report was reviewed by the operations manager and shared with the Trust's senior management team. This arrangement had been discussed and agreed	Fully Met

				with the Trust's governance department and the ward's senior management team.	
10		It is recommended that the ward manager ensures that patient and ward bathrooms are fitted with appropriate storage and towel rails.	1	The inspector reviewed three patient bathrooms and one ward bathroom and evidenced that bathroom cabinets had been fitted to each room. Towel rails were not available and the inspector was informed that the selection and procurement of appropriate towel rails had taken longer than expected. Towel rails had been ordered and are due to be fitted by the end of March 2015.	Fully Met
11		It is recommended that the ward's assistive technology devices are reviewed and any deficits or shortfalls are addressed.	1	The inspector reviewed the ward's alarm systems. Staff explained that patient bedroom doors were fitted with alarms which were used to notify staff if a patient left their bedroom. The inspector was informed that door alarms were not in use. The inspector was told that a door alarm was switched on if a patient was unwell and it had been assessed as necessary to notify staff should the patient choose to leave their room. Staff reported that all of the door alarms were working. A patient alarm was available in each patient's bathroom. These alarms could be activated by patients to notify staff if the patient required assistance. The inspector was informed that all of the bathroom alarms were working. The inspector met with both deputy ward managers who relayed that the Trust's maintenance services responded promptly to any concerns regarding the ward's alarm systems. The ward had recently been fitted with two magnetic door catches which ensured that the entrance to the patient's dining areas remained accessible at all times. The magnets disengaged and the doors closed automatically when the ward's fire alarm was activated. Both catches were noted to be working.	Partially Met

				The ward staff team continued to use patient bed mats to provide patient's with increased support and to assist staff in monitoring patients who remained unwell. The mats notified staff if a patient got up and out of bed during the night. Three of the mats were reported as requiring repair. The inspector was informed that mats were repaired on a regular basis. Three assistant technology equipment providers had carried out an assessment of patient/ ward needs with a view to updating/replacing the current system. The ward's operations manager informed the inspector that a new system had been ordered. A timeline for the installation of the new system will be finalised by the end of March 2015.	
12		It is recommended that the ward manager ensures that fire doors to patient dining areas, the ward gardens and group rooms are reviewed and where appropriate fitted with magnetic catches to ensure continued patient access and fire safety.	1	A review of the ward's fire doors had been completed and magnetic catches had been fitted to the entrance doors to each of the ward's dining areas. Magnetic catches for the doors to the ward's group room and garden areas had been considered and assessed as not appropriate. New handles had been fitted to the doors leading to the ward's central garden areas.	Fully Met
13		It is recommended that the ward manager ensures that the shutter between the kitchen area and the dining room in the ward's six bedded annex is repaired.	1	The inspector reviewed the ward's kitchen area and noted that the shutter between the kitchen and the dining room located in the ward's six bedded annex had been repaired and was working properly.	Fully Met
14		It is recommended that the Trust ensures that patients in the ward have ward based access to a physiotherapist.	1	The inspector was informed that patients on the ward received support from the physiotherapist department, located in the adjoining general hospital, as required. Staff who met with the inspector reported no concerns in being able to access a physiotherapist as required. The	Fully Met

				inspector noted a physiotherapist visited a patient on the ward during the second day of the inspection.	
15		It is recommended that the ward manager ensures that access to the ward's IT system is secure.	1	The inspector reviewed the ward's computers on a number of occasions during the inspection and noted that screens were locked as required and computer access passwords were not displayed.	Fully Met
16		It is recommended that the ward's gardens are cleaned and appropriately maintained.	1	The inspector reviewed the ward's two internal gardens and the external garden. The external garden was in the process of having a new boundary fence built. All three gardens were noted to have been appropriately maintained.	Fully Met

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
17	It is recommended that the ward manager ensures that all items brought into the ward on admission are recorded, with appropriate completion of records and receipting.	The inspector reviewed the ward's patient property book and patient cash deposit and withdrawal receipt books. The books recorded an inventory of all items brought into the ward by each patient. Records within each of the three books had been signed by two members of staff and patient's property and monies were noted to have been managed in accordance to Trust policy and procedure.	Fully Met
18	It is recommended that the ward manager ensures that accurate records are maintained monies kept on the ward, received by patients or relatives or transferred to the cash office.	The ward's procedures for handling patient's monies were noted to be appropriate and in accordance to Trust and regional guidance. When a patient was admitted to the ward an inventory of all their property and money was recorded. In circumstances were a patient may present with a large sum of money this was recorded and appropriate action taken to secure the money on behalf of the patient. Staff recorded the amount of money received and the action taken. If a relative retained the patient's money staff recorded	Fully Met

		this in the patient's care records and completed an entry into the ward's cash receipt book prior to asking the relative to sign for the patient's money. In circumstances where patient's money was retained by the Trust the ward utilised two receipt books. One book was used to record patient's money upon the patient's admission and prior to the money being deposited to the Trust's cashier office located in the adjoining general hospital. The inspector noted that the cashier office returned a receipt of lodgement which contained the patient's Trust account details. Records reviewed by the inspector evidenced that the cashiers receipt was stapled to the original receipt completed by ward staff. The second cash book was used to record cash withdrawn from the cashiers' office. The book contained a receipt of the amount withdrawn and a cashier's receipt confirming the withdrawal. Entries to both books were signed by two members of by staff. The ward manager completed a monthly finance audit which included scrutiny of the ward's deposit and withdrawal books.	
19	It is recommended that the ward manager ensures that clear & accurate records are kept at ward level of withdrawals made from the cash office by patients or staff.	The ward manager had introduced a cash lodgement and a cash withdrawal receipt book. The inspector reviewed both books and noted that they provided a clear record of patient monies deposited and withdrawn from the Trust's cash office located in the adjoining general hospital. Each entry to the books included a receipt from the cash office confirming the amounts lodged and withdrawn.	Fully Met
20	It is recommended that the ward manager ensures that individual statements are received from the cash office in order to verify if the transactions are correct and facilitate reconciliation of expenditure and receipts.	The inspector reviewed the ward's lodgement and withdrawal receipt books and noted that an individual statement was available for each patient. The receipt confirmed the amount lodged or withdrawn and these matched the entries made in the ward's receipt books. Two staff signatures were available against each transaction.	Fully Met
21	It is recommended that the Trust policy for management of patients' finances is updated as a	The Trust's policy for the handling of patients' cash and valuables was updated in April 2014. Staff had been informed of	Fully Met

	matter of urgency, and staff updated and trained accordingly.	this during staff meetings and the management of patient finances remained a standing item on the staff team meeting agenda. Staff meeting records reviewed by the inspector evidenced that staff meetings were held on a regular basis. It was positive to note that all staff had completed up to date safeguarding vulnerable adults training. This training promotes the protection of patients and the impact and implications of financial abuse.	

Quality Improvement Plan

Unannounced Inspection

Downe Dementia Ward, Downe Hospital

22 and 23 January 2015

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

The specific actions set out in the Quality Improvement Plan were discussed with the charge nurses, nursing staff, social work staff and the operations manager on the day of the inspection visit.

Any matters that require completion within 28 days of the inspection visit have also been set out in separate correspondence to the operations manager.

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	Section 5.3.3(d)	It is recommended the Ward Manager audits training records to identify gaps in knowledge and skills and ensure attendance at required training	3	25 February 2015	A visual aid board has been designed and placed in the staff room which will record each staff member's individual training record. This board is colour coded (RAG rated) identifying the trust mandatory training matrix and bespoke training required for staff working in Dementia. Completed training for all staff is recorded on this as well as when renewal / updates are required for each individual person. Each staff member now has their own individual training record to ensure all staff are aware of their responsibilities in relation to attending and recording all training undertaken. A training report is updated on a monthly basis for each member of staff with regard to

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No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
					adherence with mandatory training. The Ward Sister /deputy will carry out monthly audits of individual training records to ensure staff are attending/completing training. Any deficit will be raised immediately with individual staff. The Assistant director will monitor mandatory training compliance through the quarterly Directorate Governance report Training will remain a standing item on the agenda at monthly team meetings.
2	Section 5.3.1(a)	It is recommended that the ward manager ensures that all assessment and care documentation is completed in accordance with Trust and clinical standards	2	Immediate and ongoing	5 to 10 patient notes will be audited per month depending on patient turnover. Any outstanding action is recorded on an action plan and discussed with the invidual primary nurse who will also be provided with a written copy.

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
					Records will then be re-audited to ensure compliance. The audit report will be discussed at monthly staff meetings
3.	Section 5.3.1 (a)	It is recommended that the ward's assistive technology devices are reviewed and any deficits or shortfalls are addressed.	2	Immediate and ongoing	Assistive technology is currently available within the ward in the form of: Staff alarms, Intruder alarms, Alarms on external doors We have submitted a capital bid to upgrade the current falls system, however in the current financial climate there are limited funds for capital spend. Failing capital monies becoming available, we will continue to explore various opportunities to successfully achieve the required funding to upgrade this system.
4	Section 5.3.1.(a)	It is recommended that the ward manager ensures that the falls	1	30 April	The Falls care pathway has now been placed in care pathway section of notes and will be audited

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
		risk care pathway is implemented as required.		2015	via the monthly records audit to ensure compliance. Any compliance issues will be recorded on an action plan and discussed with the invidual primary nurse who wil also be provided with a written copy. Action plans will be re-audited and outcomes discussed with individual primary nurse and at team meetings for wider learning.
5	Section 5.3.1.(a)	It is recommended that the Trust reviews the ward's procedure in relation to the implementation of the ulcer risk assessment (Braden scale) and ensures that the scale is implemented in accordance to each patients assessed need.	1	30 April 2015	Current pressure ulcer policy is with SET policy scrutiny panel for review. Following advice from the Trust's lead Tissue viability nurse, the braden will be completed on a weekly basis within in- patient MHSOP and/or if there is a change in a patient's acutity. The tissue viability policy will be amended to provide clarity
6.	Section 5.3.1.(a)	It is recommended that the ward manager ensures that the malnutrition universal screening tool (MUST) assessment is implemented in accordance to the required standard.	1	Immediate and ongoing	The Must tool will be completed for all patients on a weekly basis.The ward manager will complete monthly audits to ensure compliance. Any compliance issues will be recorded on an action plan and discussed with the invidual primary nurse who is also provided with written copy.

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
					Outcomes of audits will be discussed at monthly team meetings for wider learning.
7.	Section 5.3.1.(a)	It is recommended that all restrictive practices on the ward and blanket restrictions in response to individual risk are reviewed to insure that risk management strategies are based on individual assessment.	1	Immediate and ongoing	All care-plans will include a rationale as to why the patient requires the use of a locked door and their specific individual need.This will be audited as part of the monthly records audit.

NAME OF WARD MANAGER	Paula Thompson

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

COMPLETING QIP	
NAME OF CHIEF EXECUTIVE / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Nicki Patterson Director of Primary Care, Older People & Exec Director of Nursing

Inspector assessment of returned QIP				**Inspector**	**Date**
		Yes	**No**		
A.	Quality Improvement Plan response assessed by inspector as acceptable	x		Alan Guthrie	13 March2015
B.	Further information requested from provider				