The Regulation and Quality Improvement Authority

RQIA

Mental Health and Learning Disability

Unannounced Inspection

Ward 27

Downshire Hospital

South Eastern Health and Social Care Trust

4 & 5 November 2014

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1.0 General Information

Ward Name	Ward 27
Trust	South Eastern Health & Social Care Trust
Hospital Address	Downshire Hospital Ardglass Road Downpatrick BT30 6RA
Ward Telephone number	028 44613311
Ward Manager	Liz McLaughlin
Email address	liz.mclaughlin@setrust.hscni.net
Person in charge on day of inspection	Liz McLaughlin
Category of Care	Mental Health
Date of last inspection and inspection type	31 July 2014, Patient Experience Interviews
Name of inspector(s)	Wendy McGregor

2.0 Ward profile

Ward 27 is a 15 bedded mixed gender ward on the ground floor of the Dixon Block, Downshire Hospital. The purpose of the ward is to provide a Psychiatric Intensive Care Unit (PICU) and low secure unit to patients with acute and long-term mental health problems. The main entrance doors to the ward are locked. Access to and from the ward can be gained via key fob. Patients on the ward have access to a multi-disciplinary team consisting of nursing and medical staff, occupational therapy and social work. Access to psychology was via referral.

The ward environment was clean and brightly lit. Male and female sleeping areas were separate. Sleeping areas were available in either a four bedded bay area or single room. Single rooms were allocated for patients who were assessed as requiring psychiatric intensive care. The ward had a large day space and a separate dining room. Male and female bathrooms were separate. The ward had a low stimulus room, and a seclusion room. The ward also had an activity room.

The ward had sixteen beds on the days of the inspection. There were fourteen inpatients and two patients were on leave on the days of the

inspection. Fourteen patients were detained in accordance with 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 Ward 27, Downshire Hospital was undertaken on 4 and 5 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 16 and 17 December 2014 were evaluated. The inspector was pleased to note that all of the six recommendations had been fully met and compliance had been achieved in the following areas:

- The management of actual and potential harm to patients from others on the ward was reviewed;
- Actions were taken to address any deficits in the protection of vulnerable adult process;
- The protection of vulnerable adult process was closely monitored and ensured that any need for protection plans was identified in relation to the safety of patients in Ward 27;
- The ward manager ensured risk assessments in relation to risk from others were developed and reviewed regularly when necessary;
- The ward manager ensured that documentation pertaining to patients subject to seclusion were completed and were available for review during inspection;
- The ward manager ensured care-plans were developed when risks to patients safety were highlighted;

4.2 Review of action plans/progress to address outcomes from the patient experience interview inspection

The recommendations made following the patient experience interview inspection on 31 July 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:

- The Trust had conducted a review of smoking facilities for patients on the ward and ward specific guidance in relation to access to smoking facilities was developed and made available to patients on the ward. Patient views were sought and considered as part of this review;
- The Trust reviewed the provision of food to ensure the needs of patients with alternative dietary requirements were met and individual dietary needs of all patients were catered for;

4.3 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

recommendations had been fully met and compliance had been achieved in the following areas:

- A record of the staff member who obtains the key to the locked cupboard in Ward 27, and the reason for access was maintained.
- The Trust policy for approval and authorisation of expenditure for larger items was developed and implemented.

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

A serious adverse incident had occurred on this ward on 7 August 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 relation to:

- Anti-absconding work had been implemented in Ward 27 and was monitored by the Ward Manager.
- Staff had maintained a high level of communication with patients family's to promote their involvement and support of the care and treatment plan.

Details of the above findings are included in Appendix 1.

5.0 Inspection Summary

Since the last inspection it was good to note that all recommendations made following the previous announced inspection, patient experience interview inspection and finance inspection had been fully met.

It was good to note that staff were familiar with Safeguarding Vulnerable Adults processes and had completed the appropriate documentation.

The inspector was pleased to note the level of Occupational Therapy services on the ward was conducive to the needs of the patient population on the ward. There were also activities provided by an activity nurse.

It was also good to note that care and treatment on the ward was based on a recovery based approach.

The inspector was pleased to observe the level of staff and patient engagement on the ward and noted that communication was respectful and therapeutic. During the inspection the staff were observed to treat the patients with courtesy and respect. The inspector observed staff making themselves available to patients, answered patients' queries promptly and appropriately and offered patients clear direction and reassurances.
It was good to note that patients were offered one to one time on a daily basis, and the content of the one to one time was recorded in the patients care documentation. It was noted that incidents of seclusion, physical intervention

and safeguarding vulnerable adult concerns were discussed with the patient during the one to one time.

The inspector noted monthly patient forum meetings were convened, and minutes recorded showed that patients had the opportunity to discuss their concerns in relation to environmental issues, smoking, and food. Patient suggestions were acknowledged and solutions offered.

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 in relation to capacity to consent was available for staff and patients. Care documentation reviewed demonstrated that patients' capacity to consent was assessed. There was evidence of patient involvement in their care and treatment plans. However, patient attendance at their multi-disciplinary team assessment meetings was not clear. A recommendation had been made in relation to this.

There was evidence in the documentation of relative involvement with decisions in relating to patients care and treatment. Patients' capacity to consent was assessed and reviewed at their multi-disciplinary team assessment meetings. It was noted that patients had the opportunity to discuss their care and treatment daily during their one to one time with either their primary or associate nurse. Patients were reviewed by their consultant psychiatrist on a weekly basis. Changes to care and treatment were discussed with the patients and their family where appropriate. There was no record of an assessment of capacity for patients' whose finances were managed by the hospital. The ward sister confirmed that this was not completed. A recommendation has been made in relation to this. Care plans had been completed in relation to administration of medication, and detailed that information was given to patients in relation to the therapeutic benefits of the medication. Care plans did not include any reference to seeking consent from the patient before any care or nursing procedures. A recommendation has been made in relation to this. Patient signatures were evident in the care documentation reviewed. Human Rights article 8 respect for private and family life and article 14 to be free from discrimination. Not all staff had received up to date training on capacity to consent. Staff indicated their knowledge of capacity to consent.

Patients had individualised and holistic assessments completed. Risk assessments had been completed and risk management plans developed for each identified risk. Risk assessments had been discussed with the patient and their relatives (with consent), there was evidence of patients signatures on the care documentation. Risk assessments and risk management plans were reviewed and updated following any incidents, vulnerable adult referrals and any incidents resulting in the use of any restrictive practices such as physical intervention or seclusion. Three out of the four sets of care documentation reviewed, evidenced that individualised care plans had been developed and addressed each of the patients' needs assessed. One set of

care documentation was incomplete as care plans had not been completed since the patients' admission on 29 October 2014. This was addressed with the ward sister. The ward sister stated they had been informed by the patients' primary nurse that the documentation had been completed and due to a technical difficulty the care plans had not been printed. The ward sister informed the inspector this would be promptly addressed with primary nurse as a performance issue and appropriate measures put in place. The patients care documentation was completed and available on the second day of the inspection. A recommendation had been made in relation to this. The ward sister informed the inspector that a weekly patient record audit was completed, every Wednesday; the inspector reviewed the audit records which evidenced this.
Multi-disciplinary team assessment meetings were convened weekly for patients requiring care in a Psychiatric Intensive Care Unit (PICU) and two weekly for patients requiring a low secure environment. Patient attendance at the meeting was not recorded in the minutes. A recommendation has been made in relation to this. However, patient attendance or otherwise was recorded in the patients progress notes. Untoward incidents, Safeguarding Vulnerable Adults, episodes of physical intervention, seclusion, medication, level of pass were discussed at the meeting.

Two patients interviewed stated the doctor had discussed their care and treatment plans with them. There was evidence in the four sets care documentation reviewed that patients Human Rights article 8 the right to privacy and family life had been considered.

All patients had access to Occupational Therapy (O.T). Individualised assessments in relation to therapeutic and recreational activities had been completed. Individualised therapeutic and recreational activity plans were developed and considered patients likes / dislikes and choices. Patient participation or otherwise was recorded in the patients care documentation. Patients could access a number of facilities of the ward such as a "tea room", the hospital canteen, and the Occupational Therapy department. The ward sister stated that patient's place particular value on these resources as somewhere to go to when off the ward. The "tea room" was noted to be poorly lit, and the décor had not been well maintained. This was an important outlet for patients' as it promoted socialisation and rehabilitation. A recommendation will be made in relation to reviewing this environment. An O.T attends the ward daily to offer activities to patients who have been assessed as not being well enough to leave the ward environment. A schedule of activities on offer on the ward was displayed.

Patients had been informed of their rights in relation to detention processes and appealing the Mental Health Review Tribunal. Patients interviewed indicated they had been informed of their rights to appeal to the Mental Health Review Tribunal. Both patients were aware of who to speak to if they were concerned or wanted to make a complaint. Patients' were informed of their rights in relation to the right to refuse care and treatment and this was recorded in their care documentation.

Information on how to make a complaint and accessing independent advocacy services was displayed in the patients' communal area.
The advocate visited the ward at least weekly and attended the patient forum meetings. Patients were referred shortly after admission to the advocate. The advocate supported the patients on request with appointments with the consultant psychiatrist. The advocate stated issues raised by patients were addressed promptly by the ward sister. A ward information booklet was available on the ward which detailed how to make a compliment and complaint and accessing independent advocacy services. Information in relation to contact details of other agencies that may assist with patients with concerns and complaints was not available. e.g. RQIA, Ombudsman patient and client council, and registrants professional bodies. A recommendation has been made in relation to this.

Individual assessments had been completed by the multi-disciplinary team in relation to restrictive practices and deprivation of liberty. There was evidence of patient and where appropriate relative involvement. A clear rationale was recorded for each restrictive practice and deprivation of liberty and demonstrated that the restriction was proportionate to each risk identified. Restrictive practices and deprivation of liberty was discussed at the multi-disciplinary team assessment meetings. Episodes of seclusion, enhanced observation and physical intervention were discussed with the patient, and the ways to reduce the likelihood of this reoccurring.

Care documentation identified triggers for any behaviours that challenge and detailed de-escalation techniques to be used. The care documentation demonstrated restrictive practices were used as a last resort. It was good to note in one set of care documentation that staff had completed an antecedent, behaviour and consequence chart following an increase in one patient's behaviour that challenged and this identified the causes for the behaviour, staff were then able to identify ways to reduce the behaviour.

Patients were assessed for differing levels of pass of the ward; the level of pass was discussed by the multi-disciplinary team however the overall decision was made by the consultant psychiatrist, based on presenting risks and current mental health of the patient. Pass was regularly reviewed according to patient need.

All staff working on the ward had received up to date training in the use of physical interventions. Records in relation to episodes of physical intervention and seclusion had been completed in accordance with trust policy and procedure. Human Rights articles 3; the right to be free from torture inhuman to degrading treatment and punishment, article 5; the right to liberty and security of person were considered and recorded in the documentation.

The inspector was informed by the ward sister that there were no delayed discharges on the ward on the days of the inspection. Discharge processes were discussed at the initial multidisciplinary team assessment meeting following admission. However, not all patients had a discharge care plan completed. A recommendation has been made in relation to this. The ward

sister stated that when a date of discharge had been decided an enhanced care planning meeting was convened. The inspector reviewed an enhanced care plan completed for one patient and noted relative and community staff involvement.

Details of the above findings are included in Appendix 2.

On this occasion Ward 27 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	**2**
Ward Staff	**4**
Relatives	**0**
Other Ward Professionals	**2**
Advocates	**1**

Patients

Both patients interviewed stated they were happy with their care and treatment. Both patients stated they had the opportunity to meet with their primary nurse and doctor. Both patients stated that “staff were nice”.

Relatives/Carers

The inspection was unannounced; there were no relatives available to speak with the inspector during the inspection.

Ward Staff

The inspector spoke with four staff during the inspection. Staff indicated that there was good team work in the ward and the ward sister was approachable and supportive. Staff stated they had received appraisals. Staff indicated that due to the mix of patients requiring a psychiatric intensive care environment and those requiring a low secure environment can be challenging as patients are at different stages of their recovery.

Ward staff raised concerns in relation to back up if there is an incident, due to the closure of the other ward on site. The inspector discussed this with the Mental Health Hospital Manager and lead nurse, who informed the inspector that they were aware of this concern and would be attending the staff meeting the following day to discuss this with staff.

Other Ward Professionals

The inspector met with the ward doctor and occupational therapist. Both professionals stated the team work on the ward was good and all staff were efficient at sharing information.

Advocates

The inspector met with the independent advocate. The advocate stated that issues raised at the patient forum meetings were always addressed promptly by staff. The advocate stated the staff referred patients promptly and appropriately following admission. The advocate stated they had not received any complaints from patients in relation to the use of seclusion physical interventions or enhanced observations used on the ward.

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	13	4
Other Ward Professionals	5	0
Relatives/carers	15	5

Ward Staff

Four questionnaires were returned from nursing staff. Staff stated they had received up to date training in Capacity to Consent and Human Rights and were aware of Deprivation of Liberty Safeguards - Interim Guidance (2010). Staff were aware and detailed what restrictive practices were used on the ward. Staff stated patients' communication needs were recorded in their assessment and care plan and all staff were aware of alternative methods of communication. Staff stated that information in relation to the Mental Health Order; detention processes; how to make a complaint and how to access advocacy services was available on the ward. All staff stated that patients have access to therapeutic and recreational activities and that activity programmes had been developed to meet patients individual needs.

Other Ward Professionals

There were no questionnaires returned from other ward professionals.

Relatives/carers

Five questionnaires were returned from relatives. All questionnaires returned stated that care on the ward was either good or excellent. Three relatives indicated that they had no concerns in relation to their family members' capacity to consent. Where relatives had stated they were concerned about their family members' capacity to consent they stated a formal assessment had been undertaken. All relatives stated they had been offered the opportunity to be involved in decisions in relation to their family members care

and treatment. Three out of five relatives stated their family member had an individual assessment completed in relation to therapeutic activity, the other two relatives stated they did not know. Four out of the five relatives stated their family member takes part in therapeutic and recreational activities, one stated “sometimes”. One relative stated their family member required an assessment of their communication needs and that this had been completed. Three relatives stated their family member did not require an assessment of their communication needs and one stated they did not know. Three relatives stated their family member had been informed of their rights and two relatives stating they did not know. Two relatives stated a person centred discharge plan had been completed for their family member, the other three stated they did not know. All five relatives stated they were aware restrictive practices on the ward.

One relative quoted that;

“Having met most of the nursing staff I experienced nothing but courtesy and understanding to include also the consultant psychiatrist who took time out from his busy schedule on two occasions to talk to us length.”

7.0 Additional matters examined/additional concerns noted

Complaints

Prior to the inspection, the ward forwarded a record of twelve complaints between 1 April 2013 and 31 March 2014. The inspector reviewed the records in relation to the complaints and noted that there was records of the twelve and all complaints had been managed in accordance with policy and procedure.

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 16 and 17 December 2013

No.	Reference.	Recommendations	Number of times stated	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	Doc No: 17 5.3.1 C	It is recommended that the Trust ensures that the process for management of actual and potential harm to patients from others on this ward will be reviewed.	1	The ward sister stated the Trust had reviewed this process. Where there was the potential of harm to patients from others a protection plan was completed. The inspector reviewed care documentation in relation to a patient who was assessed as vulnerable to harm from others. A protection plan had been completed and detailed the control measures in place to protect the patient from harm from others. This was also recorded in the patients risk assessment and a management plan had been developed. Training records reviewed showed that all staff working on the ward had received up to date training in Safeguarding Vulnerable Adults and Physical intervention training. On the days of the inspection the inspector observed that staff were present in the patient communal areas at all times**.**	**Fully met**
2	Doc No: 17 5.3.1 C	It is recommended that the Trust ensures actions will be taken to address any deficits in the protection of vulnerable adult process;	1	The inspector spoke with four staff during the inspection. Staff were familiar with the Safeguarding Vulnerable Adult policy and procedure. The inspector noted in one set of care documentation a protection plan had been completed in relation to the vulnerability of a patient who was at risk from harm of	**Fully met**

				others. The inspector also noted in four sets of care documentation reviewed that assessments included the risk of harm to others, and a risk management plan was completed where this was appropriate. The inspector noted up to date guidance in relation to Safeguarding Vulnerable Adults was available for staff.	
3	Doc No: 18 15.12 15.13	It is recommended that the Trust ensures that the protection of vulnerable adult process will be closely monitored to ensure that any need for protection plans are identified to ensure the safety of patients in Ward 27.	1	The inspector was informed by the ward sister that all vulnerable adult referrals are monitored by the designated officer. Where a referral has been completed, an interim protection plan is completed, risk assessments are updated and the referral is discussed at the team assessment meeting. The inspector reviewed one set of care documentation in relation to a vulnerable adult referral and noted the following documentation; the referral had been sent to the designated officer, a protection plan had been completed and the risk assessment and management plan had been updated. Minutes from the multi-disciplinary team assessment meetings detailed that the vulnerable adult referral had been discussed.	**Fully met**
4	Doc No: 16 4	It is recommended that the ward manager ensures risk assessment in relation to risk from others is developed and reviewed regularly when necessary.	1	The inspector reviewed four sets of care documentation. The inspector noted risk assessments and management plans had been developed and documented where there was a risk from others. The inspector noted risk assessments where reviewed regularly and discussed at the multi-disciplinary team assessment meetings.	**Fully met**

5	Doc No: 2 26.1	It is recommended that the ward manager ensures that documentation pertaining to patients subject to seclusion are completed and are available for review during inspection	1	The inspector noted policy and procedure on the use of seclusion had been updated and was available for staff. The inspector reviewed documentation in relation to the use of seclusion for one patient on the ward. The inspector noted that the documentation had been completed in accordance with trust policy and procedure. A copy of the seclusion form was forwarded along with the incident form to senior management. The original copy remained in the patients file. The numbers of incidents of seclusion are reviewed by the ward sister on a weekly basis and outcomes from the review are sent to governance for monitoring.	**Fully met**
6	Doc No: 2 13.3	It is recommended that the ward manager ensures care-plans are developed when risks to patients safety are highlighted	1	The inspector reviewed care documentation in relation to four patients. Where assessments identified a risk to a patient a safety and risk management plan had been completed.	**Fully met**

Appendix 1

Follow-up on recommendations made following the patient experience interview inspection on 31 July 2014

No.	Reference.	Recommendations	Number of times stated	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	5.3.1 (f)	It is recommended that the trust conduct a review of smoking facilities for patients on the ward and ensure that ward specific guidance in relation to access to smoking facilities is developed and made available to patients on the ward. Patient views should be sought and considered as part of this review.	1	The inspector was informed by the ward sister that a review of smoking facilities had been completed. The inspector reviewed the minutes of the patient forum meetings which detailed patient involvement in the review. A Standardised Operational Policy (SOP) in relation to patients smoking was developed on 31 October 2014. The ward sister stated the SOP will be included in the ward welcome book.	**Fully met**
2	5.3.1 (f)	It is recommended that the trust review the provision of food to meet the needs of patients with alternative dietary requirements to ensure that the individual dietary needs of all patients are catered for.	1	The inspector reviewed a monthly food audit. The audit highlighted issues where the food delivered was different to what patients had ordered on the menu. This was addressed with hospitality staff by the ward sister. Menus were changed to ensure clarity. A supply of salad foods were sent to the ward, so patients can make a salad if they prefer another option.	**Fully met**

Appendix 1

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
1	It is recommended that the ward manager ensures that a record is of the staff member who obtains the key to the locked cupboard in Ward 27, and the reason for access is maintained.	The inspector reviewed records in relation to patient finances and noted a record is maintained of staff who obtain the key to the locked cupboard and included the reason for access.	**Fully met**
2	It is recommended that a Trust policy for approval and authorisation of expenditure for larger items is developed and implemented.	The inspector reviewed the South Eastern Trust Policy and Procedure on The Management of Service Users Finances December 2012. The 7.7 of the procedure detailed the following; for purchases over £100, staff should make an application in writing to the service manager for approval. For purchase of large items e.g. furniture/holidays, staff ensure three quotes are obtained to the ensure value for money and the decision is ratified by the service manager before purchase is made. Approval of expenditure must be in line with the Trusts authorisation limit. If expenditure exceeds a manager's authorisation threshold, a secondary authorisation must be sought from an appropriate senior manager.	**Fully met**

Follow up on the implementation of any recommendations made following the investigation of a Serious Adverse Incident

No.	SAI No	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	SET71.14	Staff are introducing anti absconding work in line with this initiative, which has been implemented across the Trust's Mental Health Acute Inpatients Services. This is the responsibility of all staff and is monitored by the Ward Manager this is with immediate effect.	The inspector noted the ward had introduced anti absconding work. It was noted an anti-absconding risk assessment had been completed in the three sets of care documentation reviewed. Training records	**Fully met**

			reviewed showed that all staff on the ward had completed an absconding work book.	
2	SET71.14	Staff continue to maintain a high level of communication with patients family's to promote their involvement and support of the care and treatment plan. This is the responsibility of the primary Nurse. It is monitored by the Ward manager and this is ongoing.	The inspector noted in the three sets of care documentation reviewed that there was evidence of family involvement and support of patients care and treatment plans.	**Fully met**

Quality Improvement Plan

Unannounced Inspection

Ward 27

Downshire Hospital

4 & 5 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 Mental Health Hospital Manager and lead nurse, the ward sister, consultant psychiatrist, deputy ward sister, occupational therapist and the independent advocate 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	5.3.3 (b)	It is recommended that the ward sister ensures the documentation for recording the minutes of the team assessment meeting is reviewed to ensure clarity of patient attendance at the meeting.	1	3 May 2015	Team Assessment Sheet amended to clarify patient attendance at the meeting. November 2014 - Completed and in operation.
2	5.3.1 (c)	It is recommended that the ward sister ensures that patients whose financial affairs are managed by the hospital have an assessment completed in relation to capacity to management their finances.	1	3 April 2015	Dec 2014 - Ward Manager has communicated with Finance, Consultant and Social Work partners to progress arrangements for completion of assessments in relation to capacity to manage their finances. Feb 2015 - A Patient Finance Budget Control Self-Management Tool is in development for launch Feb 2015. A proforma for patient capacity to manage finances will be developed. Existing - Trust has a procedure in place for Service User Finances (Policy SET/FIN(04)2009 – Learning Disability and Children with Disability – Management of Service User Finances). By deadline - Financial Support Agreement

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
					documentation in place will be reviewed and adapted for use. On track for overall completion by 03.05.2015 deadline.
3	5.3.1 (f)	It is recommended that the ward manager ensures that patients' capacity to consent to care and interventions is assessed regularly and documented in the patients care documentation.	1	Immediate and on going	Arrangements in place. Nov 2014 - Staff have been made aware of the recommendation and are being directed through minuted staff meetings and supervision to always seek patient consent when administering personal care and clinical interventions. Nov 2014 - Facility added to casenotes audit to record evidence of consent requested / given. In operation. Nov 2014 - Staff advised to apply for and complete Human Rights and Capacity training provided by the Clinical Education Centre – to take place by 03.05.2015.
4	5.3.1 (f)	It is recommended that the ward manager ensures that all staff attend	1	3 May 2015	Nov 2014 - Staff advised to apply for and complete

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
		training on capacity to consent.			Human Rights and Capacity training provided by the ClinicaL Education Centre – to take place by 03.05.2015. Ward Manager will monitor uptake of training to ensure completion. Dec 2014 - Work-based learning is facilitated through staff meetings and supervision.
5	5.3.1 (a)	It is recommended that the ward manager ensures that person centred care plans are completed for all patients on the ward.	1	Immediate and on going	In place pre-inspection - Audits are in place on a weekly basis and include checking on completion of person centred care plans for all patients. Dec 2014 - Work-based learning is ongoing – facilitated through supervision.
6	6.3.2 (g)	It is recommended that the ward manager reviews the ward information booklet to ensure that patients are informed of information in relation to outside agencies that may assist patients with concerns and complaints. E.g Ombudsman, RQIA, patient and client council, professional bodies.	1	3 May 2015	Changes have been made to the ward information booklet and these have been sent to the publications department for implementation an updated version will be completed and launched in advance of 03.05.2015 deadline.

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
7	6.3.2 (g)	It is recommended that the trust review the "tea room" environment. Patients' views should be sought and considered as part of this review.	1	3 May 2015	Jan 2015 - The Review of the Tea Room has been added to the agenda of the January Patients' Meeting to ensure that a collaborative patient / staff partnership approach to decision-making is taken. 08 Dec 2014 - An initial meeting between Mental Health Management and Estates Management has taken place.

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	Liz McLaughlin
NAME OF CHIEF EXECUTIVE / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	BRENDAN WHITTLE

Inspector assessment of returned QIP		**Yes**	**No**	**Inspector**	**Date**
A.	Quality Improvement Plan response assessed by inspector as acceptable	✓		Wendy McGregor	**8 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:	
• On admission care plans are devised in collaboration with the patient, reviewed daily during one to one sessions with patients and during the overall weekly review by the primary nurse/patient and MDT. Regular relatives meetings are held and patients have access to both advocacy and peer advocacy services. Advocate attends ward once weekly. • One to one time is spent with patients in a planned way by nursing staff daily and also at patient's request. Verbal and written explanation as well as other forms of communication particular to identified need is given and feedback from the patient is sought to ensure informed consent or informed decision making at all times. (For treatments –this is revisited before each treatment to ascertain capacity where this fluctuates or improves e.g. ECT). • Part 2 and part 4 MHO are involved in the care of anyone deemed as incapable of making decisions about their care and treatment. Financial safeguards such as controllers or power of attorney are also in place where there are capacity concerns in relation to finance. Advocacy & care/relative involvement is always sought. • Staff are aware of the human rights act, 1998 (HR) legislation involving articles 8 & 14. HR articles are displayed on the ward for patients and staff alike. Awareness training is accessible on eLearning as well as HR training by setrust for staff. Literature about human rights and restrictive practice is held at ward level and raised at ward meetings. Literature about 'consent' is available to patients. • All registrants act in keeping with NMC code of conduct and are aware of the confidentiality policy. All	4

Trust policies are equality screened • An Interpreter service is available if required. • The Ward welcome booklet promotes inclusivity in the language and delivery of subjects it covers.	
Inspection Findings: FOR RQIA INSPECTORS USE Only	
The inspector reviewed care records relating to four of the 14 patients on the ward on the days of the inspection and noted the following; • A multi-disciplinary team meeting was convened following admission. The minutes from this meeting detailed if the patient had capacity to consent to care and treatment. The minutes also detailed if the patient had consented to family involvement, and where this had been agreed the minutes stated that the plan had been discussed with the family. The minutes also detailed where family had contributed and commented in relation to the patients' history, care and treatment. The inspector noted however that patients attendance or otherwise at the team assessment meetings was not recorded. A recommendation has been made in relation to this. • Patients assessed as requiring care in a low secure environment were reviewed by the multi-disciplinary team 2 weekly and patients assessed as requiring care in a psychiatric intensive care unit (PICU) were reviewed weekly. The minutes of the meetings reviewed detailed if there was any change in capacity to consent. • Patient daily progress notes had been completed and detailed daily 1:1 time with their primary or associate nurse. Care and treatment was discussed with the patients and patients were given the time to comment on their plans. • There was evidence in the medical notes that patients saw their consultant psychiatrist on a weekly basis and where requested. • Where changes to care and treatment plans was recorded there was also a record that this had been discussed with the patient and their family were appropriate by both their consultant psychiatrist and primary nurse. • There was no record of an assessment for patients' capacity to manage their finances. The ward sister confirmed that this was not completed. • The inspector noted care plans in relation to administration of medication had been completed and detailed that information was given to the patient on relation to their medication in order to promote concordance and compliance. This information included the therapeutic benefits of the medication. • The inspector reviewed care documentation where patients required medical screening in relation to	Moving toward compliance

their physical health conditions. Care plans did not include seeking consent from the patient before any medical screening i.e blood screening. • Care plans written considered the patients Human Rights article 8 respect for private and family life and article 14 to be free from discrimination. • Care documentation had been signed by the patient. Information in relation to each patients' primary nurse and who was the nurse available for their daily one to one time was displayed in the ward communal area. Information in relation to capacity to consent was available for staff and patients. Training records on the ward reflected that not all staff had received formal training on Capacity and Consent, The inspector met with four of seven staff working on the ward. Staff indicated their knowledge of capacity to consent. Staff informed the inspector they seek consent from patients before all care and treatment. Staff stated that patients currently on the ward give verbal consent. Staff indicated that patients' right to refuse care and treatment is respected. Staff stated they provide patients with all the relevant information on the therapeutic benefits of their care and treatment. Two of the 14 patients interviewed stated they had met with their consultant psychiatrist and their care and treatment plans discussed. Two out of the five relative questionnaires returned indicated that they would have concerns about their relatives capacity to consent and that a formal assessment had been completed with their involvement. The other three relative questionnaires stated they had no concerns about their relatives' capacity to consent.	

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:	
• Patients and relatives (with patient's consent) are involved in care planning and decision making regarding care from the outset. Relative's feedback is welcomed and considered by the team. • Care plans comprise of holistically assessed needs and are individual and person centred. Risk management plans are also completed in collaboration with the patient/carer and particular to the individual. 1-1 sessions promote an understanding of care planning needs and are devised in collaboration with the patient including the patient's own perspective written in 'their' language. Plans are revisited daily during 1-1s and reviewed weekly. • According to individual needs, appropriate methods of communication may be used: these may include the help of an interpreter or sign language or braille and may be written or verbal. A psychologist may be asked to advise staff if there are particular challenges to communication with a patient. • Feedback is sought from patients after 1-1 sessions to ascertain understanding of treatment plan. • Families/carers are involved with patients' consent.	4

Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
The inspector reviewed care documentation in relation to four of the 14 patients on the ward on the days of the inspection and noted the following; • Assessments were individualised and holistic. • Risk assessments had been completed and risk management plans developed for each identified risk. • Risk assessments had been discussed with the patient and their relatives (with consent), there was evidence of patients signatures on the care documentation. • The daily progress notes reviewed evidenced one to one discussions with the patients' primary or associate nurse. Records showed that patients were informed of their risk assessment and risk management plan. • Risk assessments and risk management plans were reviewed and updated following any incidents, vulnerable adult referrals and any incidents resulting in the use of any restrictive practices such as physical intervention or seclusion. Three out of the four sets of care documentation evidenced that individualised care plans had been developed and addressed each of the needs assessed. One set of care documentation was incomplete as there was no care plans in place for the patient. The patient was admitted on 29 October 2014. This was addressed with the ward sister. The ward sister stated they had been informed by the patients' primary nurse that the documentation had been completed and due to a technical difficulty the care plans had not been printed. The care documentation was completed and available on the second day of the inspection, as the ward sister had completed the documentation. The ward sister informed the inspector this would be promptly addressed with the primary nurse as a performance issue and appropriate measures put in place. The ward sister informed the inspector that a weekly patient record audit was completed, every Wednesday; the inspector reviewed the audit records which evidenced this. Patients assessed as requiring a low secure environment were reviewed by the multi-disciplinary team every two weeks and patients assessed as requiring a psychiatric intensive care environment were reviewed weekly by the multidisciplinary team. Patient attendance at the multi-disciplinary meetings was not clear on the team assessment minutes; however it was recorded in the daily progress notes reviewed by the inspector. The multi-disciplinary meeting minutes reviewed by the inspector detailed discussions in relation to the patients risk assessments including untoward incidents; accidents; safeguarding vulnerable adult issues; any changes in level of risk; current level of observation; level of pass; leave and medication review. Two patients interviewed stated their doctor had discussed their care and treatment plans with them. There was evidence in the four sets of care documentation reviewed that patients Human Rights article 8 the right to privacy and family life had been considered. Four out of the five relative questionnaires returned stated their family member had been offered the opportunity to be involved in decisions in relation to their care and treatment. One questionnaire returned	Moving toward compliance

stated they didn't know. All relative questionnaires stated they had been offered the opportunity to be involved in decisions regarding their family members' care and treatment on the ward.	

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:	
Off ward activities are encouraged and facilitated by both occupational therapists and nursing staff. Each patient has an individual care plan completed in collaboration with the ward occupational therapist (OT), The OT also advises staff on appropriate individual needs in relation to activities. Activities are recorded in an activity book as well as on the patient's electronic records. There are weekly meetings with advocacy services and monthly 'forum' or community meetings –also attended by the advocate Visits with family are facilitated and off ward visits are also facilitated where possible at the earliest opportunity. Also pass off ward with family and friends is encouraged and always reviewed at the earliest opportunity after any unsettled period when this may have been temporarily discontinued. Any restriction is formally reviewed at the weekly team meeting but often reviewed with the RMO on a daily basis.	4
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
The inspector reviewed documentation in relation to four of the 14 patients on the ward. The inspector noted the following in three of the four sets of care documentation; Patients had been referred to Occupational Therapy (O.T). Individualised assessments tools had been used as appropriate for each patient. • An integrated care pathway had been completed and detailed consent was gained for OT intervention; • A recovery focused care plan developed; • Individualised therapeutic and recreational activity plans had been completed with patient involvement; • Patient likes, dislikes and choices were included in the assessment and were incorporated in the	Compliant

patients' individualised therapeutic and recreational activity plans. Individual progress notes detailed that patients were encouraged to participate in these programmes, however if they did not wish to participate in the activity sessions, non-attendance and the reason for this was also recorded in the care documentation. There was evidence in the three sets of care documentation that patient's progress during their therapeutic activity programme was recorded by both the O.T and nursing staff. Patients could access a number of facilities on the hospital site, a "tea room", the hospital canteen, and the O.T department. The ward sister stated that patients place value on these resources as somewhere to go when off the ward. The inspector reviewed the different facilities. The "tea room" was noted to be poorly lit, and the décor had not been well maintained. As this was an important outlet for patients to promote socialisation and rehabilitation, a recommendation will be made in relation to reviewing the environment. One patient was still being assessed and did not have a therapeutic or recreational activity plan in place, however it was noted that the patient was offered ward based activities. The inspector observed patients using the activity room during the inspection. Patients were offered a choice of activities conducive to their likes. The inspector was informed by the O.T, that an OT attended the ward every day and offered activities to patients who had been assessed as not being well enough to leave the ward environment. A schedule of activities on offer on the ward was displayed.	

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:	
Patients and their relatives are informed in relation to their rights. Patients are given a copy of the MHRT process on admission Patients are given a copy of their rights in relation to the detention process and this is explained to them on admission–or if too unwell revisited daily until able to understand same –patient is then asked to sign a leaflet as receipt of a written copy of their rights given and explained to them. Each patient is informed of their human rights including the right to accept/refuse care or treatment, articles 5,8, & 14 as well as all other HR rights. Each patient is given a complaint leaflet on admission. Each patient is introduced to the advocate either on the first Tuesday or if patient requests advocacy before then. Each patient is informed of their rights under article 5 and a notice is posted on the ward noticeboard to advise what they should do if they would like egress/access off-ward.	4
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
The inspector spoke with two of the 14 patients on the ward. Both patients were detained in accordance with the mental health (Northern Ireland) Order 1986. Both patients indicated they had been informed of their rights to appeal to the Mental Health Review Tribunal. Both patients were aware of who to speak to if they were concerned or wanted to make a complaint. The inspector reviewed documentation in relation to four of the 14 patients on the ward. There was evidence	Substantially compliant

that patients had been informed of their rights in relation to detention processes and their right to appeal to the Mental health Review Tribunal. There was evidence that information in relation to the right to refuse care and treatment was discussed and signed by the patient. Information on how to make a complaint and accessing independent advocacy services was displayed in the patients' communal area. The inspector met with the Independent advocate. The advocate confirmed they visited the ward at least weekly. The advocate stated they attend patient forum meetings. The advocate stated they will visit the patients on a one to one basis. The advocate stated they raise issues with the ward social workers and nurses and accompany patients on request to appointments with their Consultant Psychiatrist. The advocate stated staff are familiar with the role of the advocate and promptly and appropriately refer patients when required. Three out of the five relative questionnaires returned indicated that their family member had been informed of their rights in relation to the mental health order, how to make a complaint and access to advocacy services. The three relatives also stated they had been informed of the advocacy services available to them. Two out of the five questionnaires returned stated they did not know if their relative had been informed. The inspector reviewed the minutes of the weekly patient forum meetings and noted the following was addressed; smoking times, the cleanliness of the ward environment, and noise levels. These were noted to be addressed appropriately by the ward sister. A ward information booklet was available on the ward. There was information in relation to how to make a compliment and complaint and accessing independent advocacy services. Information in relation to contact details of other agencies e.g. RQIA, Ombudsman, patient and client council, and registrants professional bodies was not included in the ward information booklet.	

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**
Care plans are individual and person centred and 'DOL' considerations are addressed from 'a best interest' perspective on an individual basis where a particular risk is present -seeking to adopt principle of least restrictive practice at all times. Collaboration and agreement is preferable to any restriction and where, in the interests of safety, a restriction may be in place, this is continually reviewed and discontinued at the earliest opportunity when it is considered safe to do so by the team. Any restrictive practice is explained to the patient and a sound rationale given, encouraging the patient to work with the team in resolution of the problem which led to the restriction . Staff always consider human rights and DOL principles in decision making, in particular articles, 3,5,8 and 14 as evidenced in care planning..	4
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
The inspector reviewed documentation in relation to restrictive practice and deprivation of liberty in relation to four of the 14 patients on the ward. The inspector noted individualised assessments had been completed by the multi-disciplinary team in relation to restrictive practices or deprivation of liberty. There was evidence of patients and relative involvement. A clear rationale was recorded for each restrictive practice and deprivation of	Compliant

liberty and demonstrated that the restriction was proportionate to each risk identified. There was evidence in the patients' weekly / 2 weekly multi-disciplinary team assessment meetings that restrictive practices and deprivation of liberty was discussed. There was evidence in the patients care documentation that episodes of restrictive practices such as seclusion and physical intervention were discussed with the patient and the documentation detailed that the patient had been informed of the reason for the restrictive practice and also supported the patient to look at ways to reduce the likelihood of this reoccurring. The inspector noted that identified triggers for any behaviours that challenge and de-escalation techniques were recorded in the patients care documentation. The care documentation demonstrated that restrictive practices were used as a last resort. It was good to note in one set of care documentation that staff had completed an antecedent, behaviour and consequence chart following an increase in one patient's behaviours that challenge; this identified the causes for the behaviour, and therefore staff were able to identify ways to reduce the behaviour. The ward sister informed the inspector that patients were assessed for differing levels of pass on the ward; this was discussed by the multi-disciplinary team, however the overall decision was made by the Consultant Psychiatrist, and was based on presenting risks and the current mental health of the patient. Pass was reviewed regularly according to patient need. Patients were observed on the days of the inspection enquiring about their pass, this was noted to be addressed appropriately by the staff on the ward. Five out of five relative questionnaires returned indicated they were aware of restrictive practices on the ward. Training records reviewed showed that all staff working on the ward had received up to date training in the use of physical interventions. The inspector reviewed documentation completed following episodes of physical intervention and seclusion and noted this was completed in accordance with trust policy and procedure. Three out of the four staff returned questionnaires and four of the seven staff interviewed stated they were aware of Deprivation of Liberty Safeguard (DOLS) – interim guidance (2010). Human Rights articles 3; the right to be free from torture inhuman to degrading treatment and punishment, article 5; the right to liberty and security of person were considered and recorded in the documentation.	

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:	
Patients and relatives are involved in the discharge planning process from admission or when a decision has been made to discharge (for longer stay patients). Enhanced care planning meetings are conducted inviting other agencies and relatives/carers to attend Delayed discharge reports are sent every month to the HSCB. Article 8 HR law is always considered and early reintegration to the community is part of the recovery plan for all patients.	Ward manager to complete
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
The inspector was informed by the ward sister that there were no delayed dischargers on the ward on the days of the inspection. The inspector reviewed care documentation in relation to four of the 14 patients on the ward. There was evidence that discharge processes were discussed at the initial multidisciplinary team assessment meeting following admission. However, there was no evidence that a discharge care plan had been completed in three of the four sets of care documentation reviewed. Two of the five relative questionnaires returned stated their family member had a discharge plan completed, one returned questionnaire stated their relative had not, and the remaining two stated they didn't know. A recommendation has been made in relation to this. The ward sister stated that when a date of discharge had been decided an enhanced care planning meeting was convened. The inspector reviewed an enhanced care plan completed for one patient and noted relative and community staff involvement.	Substantially compliant

Ward Manager's overall assessment of the ward's compliance level against the statements assessed	COMPLIANCE LEVEL
	3/4

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