The Regulation and Quality Improvement Authority

RQIA

Mental Health and Learning Disability

Unannounced Inspection

Evish

Grangewood Hospital

Western Health & Social Care Trust

18 and 19 March 2015

npm national preventive mechanism

informing and improving health and social care
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Contents

1.0 General Information

Ward Name	Evish
Trust	Western Health & Social Care Trust
Hospital Address	Grangewood Hospital Gransha Park Clooney Road BT47 6TF
Ward Telephone number	028 7186 4379
Ward Manager	Liam Dunne
Email address	liam.dunne@westerntrust.hscni.net
Person in charge on day of inspection	Liam Dunne
Category of Care	Mental Health, female acute admissions
Date of last inspection and inspection type	11 August 2014, unannounced inspection
Name of inspector	Alan Guthrie

2.0 Ward profile

Evish is an acute admission ward situated in Grangewood Hospital. Evish provides the in-patient component of the Trust's crisis intervention service. The ward can accommodate 17 female patients in single ensuite bedroom accommodation. Three of the ward's bedrooms are located in the integrated Psychiatric Intensive Care Unit (PICU).

Evish is supported by a multi-disciplinary team including: a consultant psychiatrist; nursing staff, a clinical psychologist and a social worker. The ward manager is responsible for the management of both the Evish and Carrick wards within the Grangewood hospital. The management structure within Evish also includes a deputy ward manager. The ward is also supported by an occupational therapist.

On the day of the inspection there were 15 patients on the ward, five of whom were detained under the Mental Health (Northern Ireland) Order 1986. Two patients were on home leave.

3.0 Introduction

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

3.1 Purpose and Aim of the Inspection

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

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

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

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

3.2 Methodology

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

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

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

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

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

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

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

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

4.0 Review of action plans/progress

An unannounced inspection of Evish, Grangewood was undertaken on 18 and 19 March 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 11 August 2014 were evaluated. The inspector was pleased to note that 9 recommendations had been fully met and compliance had been achieved in the following areas:

- the ward's admission checklist had been amended to include the patient's signature;
- patients had a choice regarding who attended their multidisciplinary meeting;
- patients could meet with their consultant in private;
- a training log to evidence nursing staff training was being maintained;
- staff had received up to date training and information in relation to the application of the Trust's safeguarding vulnerable adult's policy and procedural guidance;
- procedural safeguards and robust care-plans regarding restrictions on patients be implemented to protect against arbitrary deprivation of liberty (DOLS) were being implemented;
- all staff on the ward were verifying that they had read and understood new policies introduced to the ward;
- all documentation, reviewed by the inspector, pertaining to patient care had been signed by the patient and registered nurse;
- the locked door system for the ward was being reviewed.

However, despite assurances from the Trust, one recommendation had not been fully implemented and one recommendation had been partially met.

Two recommendations will require to be restated for a third time in the Quality Improvement Plan (QIP) accompanying this report.

5.0 Inspection Summary

Since the last inspection the ward had addressed a number of previous recommendations and implemented a number of positive changes. These have included enhancing patient involvement in their care and treatment, the introduction of a staff training record and the implementation of more robust patient care plans.

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 met with five patients and six staff and reviewed five sets of patient care documentation. The inspector noted that patients were being admitted to the ward in accordance to Trust guidance. Upon admission each patient had an admissions checklist completed to ensure that the patient was appropriately admitted to the ward.

Checklists reviewed by the inspector evidenced that patients received an induction pack, an initial assessment, risk assessment and care plan. It was positive to note that patient signatures were available on each of the admission checklists reviewed. However, the inspector evidenced that the ward's patient induction pack did not reflect the ward's arrangements and required updating. A recommendation has been made.

Patient care records reviewed by the inspector included patient signatures were required. Signatures evidenced patient participation in the completion for their comprehensive assessment and patient involvement in care planning and multi-disciplinary team (MDT) reviews. Patients who met with the inspector reflected positively on their experience of ward staff and on the care and treatment they had received during their admission. Patients reported that they could attend their MDT review and that they had been involved in planning their care and treatment.

The inspector reviewed the ward's procedures for assessing a patient's capacity to consent to their care and treatment. Capacity assessments were completed upon the patient's admission and noted to be appropriate and in accordance to regional guidance. The inspector was informed that in circumstances where a patient lacked capacity, the patient's progress was reviewed daily and decisions regarding the patient's care and treatment were taken by the multi-disciplinary team (MDT).

It was good to note that patients' views and capacity were considered on a regular basis and for each care and treatment decision. The inspector was informed that decisions taken on behalf of a patient, by the MDT, were implemented in consultation with the patient's relative/carer.

The ward's MDT included nursing, medical, social work and occupational therapy staff. The MDT met on a weekly basis and patients were invited to attend. MDT care plans examined by the inspector evidenced discussions

concerning risk, patient treatment plans, patient progress and patient discharge. MDT care plans detailed agreed outcomes and the actions to be taken. Care plans reviewed by the inspector had been signed by the patient. Nursing care plans reviewed by the inspector had been developed in accordance to the individually assessed needs of each patient. Care plans in relation to a patient's physical, psychological/emotional and social needs were available and noted to be up to date. The inspector noted that care plans contained a mixture of core care plans and individualised care plans. Each plan had been signed by the patient. Care plans had also been reviewed on a regular basis.

The inspector noted that the core care plan entitled 'Locked/swipe door access on the ward' had been implemented to help insure that patients were not subjected to inappropriate restrictions or deprivation of their liberty. The care plan referenced patients' rights and discussed the reasons why the ward entrance was locked. However, the care plan did not provide a rationale as to why the patient required the use of a locked door. Whilst these arrangements were explained in the patient induction pack and discussed at MDT meetings. The locked/swipe door care plan did not reflect the individually assessed need, of a locked/swipe door, of each patient. A recommendation has been made.

The ward's locked/swipe door access was discussed with the ward manager and senior ward staff. It was good to note that the use of locked/swipe door access to the ward was subject to continuous review by the Trust. The inspector was informed that the Trust is developing a corporate policy in relation to patient/public access and exit from wards requiring locked doors/controlled environments. The policy will identify the actions to be taken by staff in relation to patients' rights the use of locked/swipe door access.

Patients and staff who met with the inspector reflected positively on the activities available in the acute day care (ADC) centre. The ADC provided support to patients from both wards located in the facility. A copy of the ward's weekly activity planner detailed that patients could access ADC activities including: relaxation and mindfulness groups, arts and crafts, card games, table tennis and mental health discussion groups.

The inspector visited the ADC and spoke with two of the facilities occupational therapists. It was positive to note that the ADC therapeutic programme was under review. The inspector was informed, by the OT staff, that the review will focus on enhancing patient recovery programmes and therapeutic interventions. OT staff reflected positively on their relationships with patients and staff from the Evish ward. Both OT staff relayed that they felt the ward's MDT was supportive and that the opinions of all staff were listened to and valued.

The ward's notice boards detailed a range of information relevant to patients. This included information in relation to patients' rights, the advocacy service and legal advice. Patients admitted to the ward in accordance to the Mental Health (Northern Ireland) Order 1986 (The Order) were provided with

information regarding the Mental Health Review Tribunal. Admission checklists reviewed by the inspector recorded that patients had been informed of their rights.

Four of the five patients who met with the inspector reported they knew who the ward's advocate(s) were and what the advocacy service did. One patient had been admitted three days prior to the inspection and had not met the advocate. The inspector met with two of the ward's advocates. The advocates reported that they felt the ward staff were "…very good" and supportive of patients. The advocates explained that their role was welcomed on the ward and the views of advocates were listened to and considered.

The inspector reviewed the ward's processes and procedures for the management of restrictive practices used with patients. Restrictive practices used appropriately within the ward included swipe access/locked entrance and exit, the removal of sharp items, the use of observation and use of physical intervention.

The inspector noted that the MDT reviewed each patient's circumstances in relation to the need for restrictive practices on a weekly basis. The MDT assessed patients' progress and ascertained if the continued use of restrictions remained necessary, appropriate and proportionate. It was good to note that the ward had implemented a locked/swipe door care plan and a restrictive practice assessment. These assessments tools had been used with each patient as a means to helping to ensure appropriate oversight of the use of restrictive practices. However, the inspector was concerned that the rationale for the use of a restrictive practice with a patient was not clearly stated. A recommendation has been made.

Staff supervision and training records for 24 members of the nursing staff team were reviewed. The inspector was concerned to note that 12 staff had not attended training in relation to the Trust's restrictive intervention policy and 16 staff had not completed up to date infection control training. The training records evidenced that staff up to date training to fulfil their designated roles in relation to infection control and the management of restrictive practices. Two recommendations made as a result of previous inspections have been restated for a third time.

Staff supervision and appraisal records evidenced a number of deficits in relation to supervision. Although it was good to note that all staff will have received an appraisal date and will have completed their appraisal by the end of April 2015.Records evidenced that a number of staff had not received their supervision in accordance to Trust and professional guidelines. A recommendation has been made.

The ward's patient induction pack provided patients with information in relation to the ward's ethos and procedures. The pack also discussed restrictions implemented during a patient's admission. The inspector noted that the pack was out of date as it did not reflect the ward's position in relation to patient

time off the ward, use of mobile phones and smoking. A recommendation regarding the induction pack has already been made.

The inspector reviewed the ward's processes for recording and reporting the use of enhanced observation and physical intervention. The inspector evidenced that staff completed observations in accordance to Trust policy and procedure. However, incident reports detailing the use of a physical intervention did not include a specific use of physical intervention record. This record should provide a description and analyses of the use of a physical intervention. A recommendation has been made.

The ward's arrangements for discharge were discussed with each patient on admission. The patient induction pack and admission template assured that staff discussed the ward's discharge policy and procedures. It was positive to note that a patient's discharge plan was supported by the Trust's Home Treatment Team and the ward' s social work and occupational therapy staff.

Discharge plans reviewed by the inspector were noted to be appropriate and in accordance with the assessed needs of the patient. Patients reported that they had been involved in their multi-disciplinary team (MDT) reviews. The MDT considered each patient's circumstances, including the patient's discharge plan, on a weekly basis.

Details of the above findings are included in Appendix 2.

On this occasion **Evish** 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	6
Relatives	0
Other Ward Professionals	0
Advocates	2

Patients

Patients who met with the inspector were positive about the care and treatment they had received on the ward. Patients stated that they could speak with staff as required and that they were invited to their weekly multi-disciplinary review. Patients reported that they had been given the opportunity to be involved in their care and treatment. Patients reflected that they felt safe on the ward. Patient comments included:

“Staff are very good”;

“I know my rights as a voluntary patient”;

“I don’t know if I can leave the ward to go for a walk”;

“Staff are not bad”;

“I love it it’s really nice”;

“I am very satisfied with my care and treatment”.

Relatives/Carers

No relatives or carers were available to meet with the inspector.

Ward Staff

The inspector met with six members of the ward’s multi-disciplinary team (MDT). Nursing staff reported that they felt supported by their line manager and that their views and opinions were listened to and considered. The occupational therapy staff reflected positively on their experiences of working with the ward and on the support they received from the MDT. All staff reflected on the wards no smoking policy and the challenges in supporting patients to stop smoking. Staff comments included:

“I feel more involved and listened to on the ward”;

“The team is supportive”;

“My views are listened to and considered”;

“Patients are very involved in their care and treatment”.

Other Ward Professionals

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

Advocates

The inspector met with two independent advocates. The advocates informed the inspector that they found the ward staff to be supportive and responsive to the needs of patients. Advocates reflected that they met with patients regularly and they felt the support for patients was good. The advocates reported that they were continuing to work alongside the ward’s staff team to ensure advocacy was fully integrated.

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	8	8
Other Ward Professionals	2	0
Relatives/carers	8	2

Ward Staff

Four nursing staff, two doctors, a social worker and an occupational therapist returned questionnaires prior to the inspection. All staff reported knowledge of the restrictive practices implemented on the ward and an awareness of the deprivation of liberty safeguards. Staff listed restrictive practices to include: physical intervention, 1:1 observations, swipe/locked entrance and exit and use of the Mental Health (Northern Ireland) Order 1986.

Staff documented that they felt patients on the ward could access therapeutic and recreational activities and activities were designed to meet patient’s individual needs. Staff comments included:

“We do our best to provide activity programmes to meet individual patient need”;

“At ward rounds we have regular discussions about human rights and the protection and safeguarding in a treatment and care context”;

“Fruit juice in the vending machines would provide a healthy alternative to fizzy drinks”;

“Since the move to the new hospital and the implementation of releasing time to care there is more time spent doing one to one and therapeutic interventions”.

Other Ward Professionals

No other ward professionals returned questionnaires prior to the inspection.

Relatives/carers

Two relatives returned a questionnaire prior to the inspection. Relatives recorded that they felt the care and treatment their loved one received on the ward was excellent. Neither relative relayed any concern about the patient’s ability to consent to their treatment. Both relatives detailed that they had been offered the opportunity to be involved in decisions in relation to the patient’s care and treatment.

Relatives recorded that the patient had received an individual assessment in relation to therapeutic and recreational activity. Relatives also reported that patients had received appropriate information in relation to restrictions used on the ward and their rights.

7.0 Additional matters examined/additional concerns noted

Complaints

The inspector reviewed the ward’s complaints records from the 1 April 2013 to 31 March 2014. Four complaints had been received by the ward during this period. Three complaints had been resolved to the full satisfaction of the complainant and one complaint had been partially satisfied. Complaints had been managed in accordance to Trust policy and procedure. Complaints reviewed by the inspector were noted to include a description of the complaint, the action taken and the outcome.

No additional concerns were noted during the inspection

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

Follow-up on recommendations made following the unannounced follow up inspection on 11 August 2014

No.	Reference.	Recommendations	Number of times stated	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	5.3.1(a)	It is recommended that the admission checklist is amended to include patient signature	3	The inspector reviewed the ward's admission checklist template. The template included a signature box for the patient to sign. The inspector reviewed five sets of patient care records. The admission checklist in each set of records had been signed by the patient.	Fully met
2	6.3.2(b)	It is recommended that choice is offered to patients regarding who attends the multidisciplinary meetings when they attend.	3	The inspector met with five patients. Patients reported that they were invited to attend their multi-disciplinary team (MDT) meeting each week. Patients relayed no concerns regarding the staff who attended their MDT. One patient reported that there had been four staff members present and they would rather have met one to one. Patients' explained that they did not think they could choose who attended their MDT. The inspector asked patients what they would do if they were unhappy about a staff member attending their meeting.	Fully met

				Patients stated that they would discuss this with nursing staff. The patients who met with the inspector reported that they felt ward staff were helpful and easy to talk too. Patients detailed that they felt staff would support them with any concerns they might have. The inspector discussed MDT meetings with the ward manager. The manager stated that during MDT meetings staff met first prior to the patient attending. The ward manager stated that only those staff working directly with the patient remained in the meeting. The ward manager assured the inspector that if a patient was uncomfortable or was concerned about a member of staff attending this would be addressed.	
3	6.3.2(b)	It is recommended that there is evidence that patients have a choice to meet consultants in private.	3	The inspector reviewed the ward's patient induction pack. The pack evidenced that patients were informed that they had the right to speak with their consultant in private. Each patient who met with the inspector stated that they had received an induction pack upon their admission. One patient reported they were unsure if	Fully met

				they could meet with their consultant in private.Two patients had not considered this as they had met with their consultant at the MDT meeting. One patient had requested to meet with their consultant in private. The patient had been informed that the meeting would take place as soon as possible. The patient had been admitted to the ward three days prior to meeting with the inspector.	
4	4.3(m)	It is recommended that a training log is maintained to evidence staff training particularly mandatory training.	3	A nursing staff training log was available. The log recorded the name of each member of nursing staff and a list of the mandatory training requirements. The log detailed the completion dates of training and the dates of future training. The inspector noted training deficits in relation to infection control and child protection refresher training. 16 staff had not completed up to date infection control training and 19 staff required child protection refresher training. It was positive to note that the ward manager had prioritised this training and staff were scheduled to complete the required child protection refresher training by the end of	Fully met

				March 2015. A recommendation regarding the completion of mandatory training has been restated . The recommendation is detailed in the quality improvement plan accompanying this report. Training records for medical, social work and occupational therapy staff were retained by the staff members' professional manager. The ward manager reported that the mandatory training of other professionals was monitored by the acute services manager.	
5	8.3(i)	It is recommended that the ward manager ensures that all staff receive training and information in relation to the application of the Trust's safeguarding vulnerable adult's policy and procedural guidance.	2	The inspector reviewed the ward's nursing staff training records and the safeguarding vulnerable adults' process. The inspector also spoke with four members of the nursing staff team. Training records evidenced that 15 of the wards 24 nursing staff had completed up to date training. Seven members of staff were scheduled to complete up to date refresher training on the 25 March 2015. Safeguarding vulnerable adults' refresher training for other members of the multi-	Fully met

				disciplinary team (MDT) was monitored by the staff members' professional lead. The inspector was informed that the training records of other professionals within the MDT were monitored by the acute services manager. Information regarding the ward's safeguarding vulnerable adult processes (VA) was available in a file that all staff could access. The file contained up to date information and guidance. The inspector reviewed the ward's last VA referral and noted this had been completed in accordance to regional and Trust policy and procedure.	
6	5.3.1(c)	It is recommended that the trust ensures that procedural safeguards and robust care-plans regarding restrictions on patients be implemented to protect against arbitrary deprivation of liberty (DOLS)	2	The Trust's policy for the use of restrictive interventions with adult service users had been reviewed in August 2014 and was available on the Trust's intranet. The inspector reviewed five sets of patient care plans. Plans were noted to be hand written and based on the individually assessed needs of each patient. Patients had signed their care plans. The inspector evidenced that the ward's	Fully met

				multi-disciplinary team reviewed each patient's circumstances on a weekly basis. This included a review of the restrictive practices used to support the patient's care and treatment. It was good to note that the ward had introduced a locked/swipe door care plan. The inspector was informed that the plan had been introduced to help ensure that patients were protected against any unnecessary deprivation of their liberty. However, the locked/swipe door care plan did not provide a rationale as to why the patient required the use of a locked door. The care plan also failed to explain the arrangements if a patient wanted to go for a walk or leave the ward unaccompanied. The inspector noted that patient care plans also included an 'Application of restrictive interventions' assessment. The assessment recorded the type(s) of restrictions used with the patient and included a monitoring record. The assessment detailed that the use of a restrictive practice should be agreed by the multi-disciplinary team and applied in	

				the best interests of the patient. The inspector evidenced that the application of restrictive interventions assessment did not detail a rationale for the use of restrictions. The assessed need to remove a patient's personal property or items that could present as a ligature risk was not explained. A new recommendation regarding the use of restrictive practices and the provision of an appropriate rationale based on the assessed needs of the patient has been made. The recommendation is stated in the quality improvement plan accompanying this report.	
7	4.3(j)	It is recommended that the ward manager reviews training records to identify any gaps in training, knowledge and skill, and sets out a plan to address any deficits in training as a matter of urgency.	2	The ward's nursing staff training log evidenced that the ward manager had reviewed training records. The training log identified gaps in mandatory refresher training regarding safeguarding vulnerable adults, child protection, and manual handling. The inspector was able to evidence that update training had been planned for staff who required refresher training. The training log recorded that all staff will	Partially met

				have completed the required mandatory training by the 31 May 2015. However, the training record evidenced deficits in relation to staff attendance at restrictive interventions training and infection control training. The inspector was informed that this training had been prioritised. The inspector was unable to confirm the dates on which this training would be provided.	
8	4.3(m)	It is recommended that the ward manager ensures that all staff receive training in relation to the application of the Trusts Restrictive Intervention policy.	2	The ward's training log recorded that 12 of the ward's 24 nursing staff had completed training in the Trust's restrictive intervention policy. The inspector noted that one nursing post was vacant, one nurse was on long term leave and two nurses had only recently been appointed. Subsequently, ten nursing staff had not completed training in relation to the application of the Trust's restrictive intervention policy.	Not met
9	5.3.1(c)	It is recommended that the ward manager ensures that all staff on the ward sign to verify that they have read and understood new policies introduced to the ward.	2	The inspector reviewed the ward manager's procedures for introducing new policies to the ward. The ward manager informed the inspector that all new policies were provided in paper copy and on the Trust's intranet. Staff were informed of the new	Fully met

				policy during the weekly team meeting and asked to sign a verification sheet detailing that they had read and understood the policy. The inspector was told that all staff have an email address and access to the Trust's intranet. The paper copy of the policy is circulated within the team alongside a signature list. Staff sign the signature list to verify that they had read and understood the policy. The ward manager explained that they monitored the policy signature list to ensure that staff had read the policy. Where signatures are not available the ward manager reviews this with the individual(s) whose signature(s) is missing.	
10	5.3.1(a)	It is recommended that the ward manager ensures that all documentation pertaining to patient care is signed by the patient and registered nurse	2	The inspector reviewed five sets of patient care documentation. Care records evidenced that patient signatures were available when required. Five patients met with the inspector. Each patient reported that they had been involved in their care and treatment. Patients' reflected that they had been asked to sign a number of their care	Fully met

				documents during their admission.	
11	5.3.1(c)	It is recommended that the trust ensures that locked door system for the ward is reviewed.	2	Minutes from the inpatient senior nurse meeting convened on the 3 November 2014 recorded that the use of locked doors was reviewed and an outcome agreed. The outcome recorded that staff felt it was necessary to continue to use locked doors to provide a safe environment. The adult mental health acute services manager informed the inspector that mental health services had maintained an open door protocol in other mental health acute care settings within the Trust. The manager stated that an open door protocol was being considered throughout Trust acute services including the Evish ward. As part of this process a further review of locked door protocols within the Evish ward will take place at the crisis service development meeting on the 26 March 2015. The inspector was informed that the review will consider the introduction of an open door protocol to the ward. A new recommendation in relation to the Trust's review of its open door protocol	Fully met

				has been made. The recommendation is stated in the quality improvement plan accompanying this report.	

Quality Improvement Plan

Unannounced Inspection

Evish Ward, Grangewood Hospital

18 and 19 March 2015

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

The specific actions set out in the Quality Improvement Plan were discussed with the ward manager, the senior social worker and the acute crisis service manager and the head of crisis services 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	Section 5.3.3 (c)	It is recommended that the ward manager reviews training records to identify any gaps in training, knowledge and skill, and sets out a plan to address any deficits in training as a matter of urgency.	3	31 May 2015	A training plan is already in use in conjunction with a mandatory training plan which is updated on a three monthly basis. Gaps in training have been identified and a plan to address the deficits within the timescale is in place.
2	Section 5.3.3 (c)	It is recommended that the ward manager ensures that all staff receive training in relation to the application of the Trusts Restrictive Intervention policy.	3	30 April 2015	The Charge Nurse will provide training sessions to staff in relation to the application of the Trust's Restrictive Interventions Policy by 31st May 2015
3	Section 5.3.3 (a)	It is recommended that the crisis service reviews and updates the patient information pack. The updated pack should include reference to the ward's current status, use of restrictive practices and patients' rights.	1	31 July 2015	The Patient Induction Pack was reviewed and updated on 08/04/15. A final meeting of the sub group who were reviewing the Induction Pack, including service users and their representatives, will take place prior to 30/06/15 to sign off on the Pack.
4	Section 5.3.1(a)	It is recommended that the ward manager and the multi-disciplinary team ensure that patient care plans and restrictive practice assessments accurately reflect the assessed needs of each patient in accordance to	1	Immediate and ongoing	This recommendation was discussed at the Nursing Staff meeting on 08/04/15, the Crisis Team Meeting on 21/04/15 and at the Crisis Development Meeting on 28/04/15. Changes to how the Multi Disciplinary Team evidence the rationale for restrictive practice was agreed.

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
		deprivation of liberty standards (DOLS).			
5	Section 5.3.3 (d)	It is recommended that the ward manager ensures that all staff receive supervision and appraisal in accordance to Trust and professional standards.	1	Immediate and ongoing	Appraisal for all staff for the 2015-2016 year has already begun and a plan is in place to ensure all staff receive appraisal in accordance with the Trust's Policy. The Charge Nurse has identified further staff for Supervisors Training to take place from 12-14th May 2015 to replace supervisors who have recently left the service. The system and allocation of staff for supervision has been reviewed by the Charge Nurse and an updated system is now in place to ensure all staff receive supervision in accordance with the Trust's Policy.
6	Section 5.3.1 (a)	It is recommended that the Trust introduces a use of a physical intervention record. This record should record reasons why the intervention was necessary, the details of the staff involved and the outcome. A copy of the record should be retained in the patient's record. A further copy should accompany the associated incident report.	1	31 May 2015	All incidents of physical intervention that occur on Evish Ward are recorded in line with WHSCT Incident Reporting Policy and Procedures through the electronic DATIX system. The development and introduction of a physical intervention record and associated systems and processes will be taken forward as a corporate matter through the Adult Mental Health Governance Group for the attention of the Trust Quality & Safety Sub-Committee.

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	Liam Dunne
NAME OF CHIEF EXECUTIVE / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Elaine Way

Inspector assessment of returned QIP				**Inspector**	**Date**
		Yes	**No**		
A.	Quality Improvement Plan response assessed by inspector as acceptable	x		Alan Guthrie	14 May 2015
B.	Further information requested from provider				