The Regulation and Quality Improvement Authority

RQIA

Mental Health and Learning Disability

Unannounced Inspection

Carrick Male Ward, Grangewood Hospital

Western Health and Social Care Trust

24 and 25 February 2015

npm national preventive mechanism

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

Contents

1.0 General Information

Ward Name	Carrick Male Ward, Grangewood Hospital
Trust	Western Health and Social Care Trust
Hospital Address	Gransha Park Clooney Road BT47 6TF
Ward Telephone number	028 71860261
Ward Manager	Liam Dunne
Email address	liam.dunne@westerntrust.hscni.net
Person in charge on day of inspection	Tony Simmons
Category of Care	Acute inpatient mental health service
Date of last inspection and inspection type	29, 30 April and 1 May 2013, announced inspection
Name of inspector	Alan Guthrie

2.0 Ward profile

The Carrick ward is an acute admission ward for males aged from 18 to 65. Located in the Grangewood hospital the ward provides assessment and treatment services and is the in-patient component of the Trust's crisis service. It has an integrated psychiatric intensive care unit (PICU).

The ward provides accommodation for up to 17 patients. Patients have access to a consultant psychiatrist; clinical psychologist, social worker and occupational therapist. Patients can attend Grangewood's acute day care centre. The centre is located opposite the ward and provides day time activities and social outings.

At the time of inspection there were ten patients on the ward. Two patients had been admitted in accordance to the Mental Health (Northern Ireland) Order 1986.

3.0 Introduction

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

3.1 Purpose and Aim of the Inspection

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

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

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

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

3.2 Methodology

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

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

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

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

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

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

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

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

4.0 Review of action plans/progress

An unannounced inspection of **Carrick Ward** was undertaken on **24 and 25 February 2015**.

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

The recommendations made following the last announced inspection on 29, 30 April and 1 May 2013 were evaluated. The inspector also evaluated the recommendations made following the last unannounced inspection on the 12 February 2014. The inspector was pleased to note that 17 of the 25 recommendations had been fully met and compliance had been achieved in the following areas:

- the ward's senior management team had reviewed the ward's swipe access/locked door procedures;
- each patient's circumstances in relation to their capacity to consent to their care and treatment had been recorded;
- staff had received training and information in relation to the application of the Trust's safeguarding vulnerable adult policy;
- all staff were informed of new Trust policies. The ward manager had introduced appropriate procedures to ensure staff had read policies;
- patient care documentation reviewed by the inspector had been signed by the patients when required;
- vulnerable adult referrals reviewed by the inspector had been completed appropriately in accordance to Trust and regional guidance;
- the locking system for the private visiting room had been reviewed. The system was due to be upgraded in the near future;
- the ward's patient activities programmes were being reviewed in partnership with the patients;
- minutes of the ward's patient/staff meeting included details of issues raised, action taken, out-comes and a list of attendees;
- guidance for staff regarding the management of the patients' social skills money was available;
- a list of the staff who handle money and staff who have access to the code for the ward safe had been recorded and maintained;
- each patient's capacity regarding the ability to keep their own property in their personal safe had been assessed;
- the ward's complaints procedures were appropriate. This included ensuring that each complainant was informed of the outcome of their complaint;
- relatives were being informed of incidents involving patients;
- the art-room within the occupational therapy department was well maintained and being used by patients on a daily basis;
- the policy on the removal of patient's cigarette lighters had been reviewed. The policy was no longer in place as the ward had introduced a non-smoking policy;
- staff could access the ward's kitchen as required.

However, despite assurances from the Trust, seven recommendations had not been fully implemented. Two recommendations had been partially met and five recommendations had not been met. Seven recommendations will require to be restated for a second time in the Quality Improvement Plan (QIP) accompanying this report.

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

The recommendations made following the patient experience interview inspection on 9 April 2014 were evaluated. The inspector was pleased to note that three recommendations had been fully met and compliance had been achieved in the following areas:

- patients could access drinks as required;
- patients could choose their dinner and teatime meals on a daily basis;
- information in relation to the availability of chaplaincy services was displayed on the ward's notice boards.

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

The recommendations made following the finance inspection on 8 January 2014 were evaluated. The inspector was pleased to note that two recommendations had been fully met and compliance had been achieved in the following areas:

- money given to the ward for use by patients was being appropriately recorded and receipted;
- appropriate, detailed and verified records of transactions made by staff on behalf of patients were being appropriately maintained.

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, reviewing the ward's policies and procedures and ensuring that staff complete up to date training.

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 six patients and reviewed five sets of patient care documentation. The inspector noted that on admission a checklist was completed with each patient to ensure that the patient was appropriately admitted to the ward. Checklists reviewed by the inspector evidenced that patients received an induction to the ward, an initial assessment, risk assessment and care plan.

Patient care records examined by the inspector evidenced patient involvement in their care and treatment. Patient signatures were available when required and patient progress notes and care plans recorded continued staff consultation with each patient. Each set of care records reviewed by the inspector included a patient details section. This section provided an overview of the patient's personal details and relevant social factors. The inspector evidenced that in two sets of patient care records the patient's details section had not been fully completed. A recommendation has been made.

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. The inspector observed the ward's atmosphere to be calm and relaxed. Nursing staff were continually available and responded to patient requests in a timely manner. Patients who met with the inspector stated that they had been involved in 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 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). The inspector was informed that decisions taken on behalf of a patient were implemented in consultation with the patient's relative/carer.

The ward's MDT met on a weekly basis. The meeting involved other ward staff including medical, social work and occupational therapy staff. Patients attended their MDT meeting and were involved in reviewing their care plan. MDT and nursing care plans examined by the inspector evidenced

discussions concerning risk, patient treatment plans and patient discharge. MDT care plans detailed agreed outcomes and the actions to be taken.

Nursing care plans identified the patient's physical, psychological/emotional and social needs and set objectives to support the patient's care, treatment and recovery. Nursing care plans reviewed by the inspector were noted to be handwritten and appropriate to the assessed needs of the patients. All of the care plans viewed by the inspector had been signed by the patient. The care plans had also been reviewed on a regular basis.

The inspector noted that the care plan entitled 'Locked/swipe door access on the ward' had not been implemented in accordance to deprivation of liberty standards (2010) (DOLS) guidance. The DOLS 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 individual patients 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. Two voluntary patients who spoke with the inspector reported that they did not know if they could leave the ward unaccompanied. A recommendation has been made.

Patients and staff who met with the inspector reflected positively on the facilities offered at the acute day care (ADC) centre. The inspector noted that not all patients attend the centre. The inspector was informed that each patient received and occupational therapy (OT) assessment prior to being able to access the ADC. Subsequently, patients recently admitted to the ward were unable to attend until the MDT had assessed attendance as appropriate.

The ADC was located opposite the ward and within the same building. The ADC provided day care support to patients from both wards located in the facility. A copy of the ward's weekly activity planner detailed that patients could access activities seven days a week. Activities available in the ADC included: relaxation and mindfulness groups, arts and crafts, card games, table tennis and mental health discussion groups.

The inspector visited the ADC and noted that it was spacious, bright and well equipped. Three OT staff who met with the inspector reflected positively on their relationships with patients and staff from the Carrick ward. The OT staff relayed that they felt the ward's MDT was supportive and that the opinions of all staff were listened to and valued.

Nursing staff provided activities for patients at night and at weekends. Activities were planned on a Sunday evening during the patient/staff meeting. Patients reported that the meeting was held on a regular basis and included discussion regarding the ADC and ward based activities.

Pre-inspection questionnaires completed by five ward staff recorded that the staff felt the ward's therapeutic programme met the needs of each patient. However, the inspector noted that there were a limited number of psychotherapeutic interventions available to patients. The inspector

discussed these concerns with the deputy ward manager and the OT staff. The inspector was informed that ADC services were in the process of being reviewed. The inspector was told, by the OT staff, that the ADC review will focus on enhancing patient recovery programmes. A recommendation regarding psychotherapeutic interventions has been made.

The Trust's psychology services provided support to patients as required. It was positive to note that patients could access the Trust's personality disorder service.

The ward provided notice boards which detailed a range of information relevant to patients. This included information in relation to patients' rights, the advocacy service and legal advice.

The ward's admission checklist included a section to ensure patients had been given information about their rights. 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. It was good to note that the hospitals' administrative team could provide this information in a number of languages. Checklists reviewed by the inspector recorded that patients had been informed of their rights.

Three of the five patients who met with the inspector reported they knew who the ward's advocate was and what an advocacy service did. Two patients had been admitted within the three days prior to the inspection and had not met the advocate. Patients who had met with the advocate reported that they had found them to be helpful and supportive.

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 evidenced that a number of the doors were locked. This included the ward's front door, office doors, the laundry and bathrooms. The inspector noted that the multi-disciplinary team (MDT) reviewed each patient's circumstances in relation to the need for a locked door on a weekly basis. The MDT assessed patients' progress and ascertained if a patient was well enough to access time off the ward. If deemed appropriate to the patient's assessed needs the patient could access unescorted time away from the ward. Patients could also avail of home leave to support their discharge and transition back to their community.

However, three of the five patients who met with the inspector reported they did not know if they could leave the ward. This included two patients who had been admitted to the ward on a voluntary basis. The inspector was concerned that patients were unaware of their rights in relation to accessing time off the ward. A recommendation regarding this issue has been made.

The inspector reviewed the ward's patient induction pack. The 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 has been made.

The inspector reviewed the ward's processes for recording and reporting the use of enhanced observation and physical intervention. 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 physical intervention. The record documents staff actions and provides detail of why the physical intervention had been necessary. The inspector was concerned that appropriate Trust governance of the use of physical intervention was not available. A recommendation has been made.

It was positive to note that 18 nursing staff had completed up to date managing actual and potential aggression (MAPA) training. The inspector was informed that the six staff requiring update MAPA training had been booked to attend the next available course.

Staff supervision records evidenced a number of deficits in relation to supervision. The inspector also evidenced that 15 staff had not received their appraisal during the previous 12 months. A recommendation regarding staff supervision and appraisal has been restated for a second time.

The inspector reviewed the ward's processes and procedures in relation to the management of patient observations. The inspector evidenced that staff completed observations in accordance to Trust policy and procedure. The inspector met with two patients who had received observations during their admission. Patients reported that the reason why observation was being used had been explained to them.

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 the Carrick ward 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	8
Relatives	0
Other Ward Professionals	2
Advocates	0

Patients

Patients who met with the inspector were complimentary regarding the care and treatment they had received on the ward. Patients were positive about their ability to access staff support. Each patient reported that they had been given the opportunity to be involved in their care and treatment. Patients informed the inspector that they could attend their multi-disciplinary team review meeting. Patients also reflected that they felt safe on the ward. Patient comments included:

“Staff are always asking if you’re alright”;

“I am very satisfied with my treatment and care on the ward”;

“Staff are good”;

“Foods great, staff are good and my room is brilliant”;

“Staff are good and helpful”;

“I would like more time in day care”.

Relatives/Carers

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

Ward Staff

The inspector met with eight members of the ward’s multi-disciplinary team (MDT). Nursing staff reported that they felt supported by their line management and that their views and opinions were acknowledged. The facilities occupational therapist reflected positively on their experiences of working in the ward and on the support and integration within the MDT. The ward’s social worker relayed that they felt the multi-disciplinary team was

effective. All staff reflected on the wards no smoking policy and the challenges in supporting patients to stop smoking. Staff comments included:

“Brilliant multi-disciplinary team”;

“Management are supportive of my role on the ward”;

“Staff are always on the floor. A minimum of two at a time are available to support patients”;

“My opinion is listened to”;

“Smoking is an issue”;

“I complete and incident report when I discover a patient is smoking. There could be a lot of incident reports”;

“I think the no smoking policy is a good idea. It will take time but I think it will work”.

Other Ward Professionals

The inspector met with the ward’s services manager and the crisis services manager and lead nurse. Both staff members reflected on the significant changes implemented in the ward during the previous twelve months. They discussed the introduction of the ward’s no smoking policy and the challenges for staff in overseeing the implementation of the policy. It was good to note that both managers worked closely with the ward.

Advocates

No advocates were available to meet with the inspector.

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	15	4
Other Ward Professionals	6	0
Relatives/carers	11	1

Ward Staff

Two doctors, a social worker and a nurse returned questionnaires prior to the inspection. All staff reported awareness of the restrictive practices implemented on the ward. All staff reported that they were aware 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. All staff documented that they felt patients on the ward could access therapeutic and recreational activities and activities were designed to meet patient's individual needs. A staff member made the following comment:

"Mindfulness sessions would be of value (to patients)"

Other Ward Professionals

No other ward professionals returned questionnaires prior to the inspection.

Relatives/carers

One relative returned a questionnaire prior to the inspection. The relative recorded that they felt the ward required improvement. The relative explained that they believed the patient lacked insight and the multi-disciplinary team decision to abide by the patient's request for confidentiality was wrong. The relative reported they felt the patient did not benefit from being on the ward. The relative indicated that their assessment was based on the fact that the patient did not receive intense one to one counselling to help them address their illness.

7.0 Additional matters examined/additional concerns noted

No additional concerns were noted during the inspection.

Complaints

The inspector reviewed the ward's complaints records from the 31 March 2013 to 1 April 2014. The inspector noted that the last complaint received regarding the ward was recorded on the 7 August 2013. The complaint 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. All of the complaints had been resolved to the satisfaction/partial satisfaction of the complainant.

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

Follow-up on recommendations made following the announced inspection on 29, 30 April and 1 May 2013

No.	Recommendations	No. of times stated	Reference	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	It is recommended that the trust continue to review the locked ward policy to ensure that voluntary patients are not disadvantaged.	2		The inspector met with the ward's service manager, the crisis services manager and lead nurse and the deputy ward manager to discuss the ward's use of locked doors. All three managers informed the inspector that the ward's doors remained locked and the use of locked doors remained under continued review. The inspector reviewed the care records of three voluntary patients. Records evidenced that each patient's circumstances remained under review. This included an assessment of the patient's time off the ward. The inspector noted that patient care plans and the multi-disciplinary team meeting minutes continually reviewed each patient's circumstances in relation to the need for a locked door. Patients could access unescorted time away from the ward provided this was in accordance to their assessed needs and the associated risk. The crisis service manager informed the inspector that the use of restrictive practices within the Carrick ward was a standing item on the agenda of the crisis services development meeting and the inpatient senior nurse meeting. 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 manager of acute services explained that the Trust had introduced an open door protocol in other mental health	Fully Met

				acute care settings within the Trust and this will now be considered for the Carrick ward. The manager detailed that the use of locked doors was due to be considered 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 Carrick ward.	
2	It is recommended where the patient lacks capacity to offer consent, this is recorded.	2		The inspector was informed, during the inspection, that all of the patients on the ward had been assessed as having the capacity to consent to their care and treatment. The inspector reviewed four sets of patient care records. Care records detailed that upon admission each patient's physical and mental health was assessed. This included a joint medical and nursing assessment of the patient's perception, cognitive function and insight. In circumstances where a patient may be assessed as lacking capacity this was recorded in the cognitive functioning and insight sections of the patient's assessment. During their admission patients were reviewed on a daily basis by nursing and medical staff and on a weekly basis by the ward's multi-disciplinary team (MDT). Each patient had a MDT care plan which was reviewed at the weekly MDT meeting. The care plan included continuous review of a patient's capacity and any associated safeguarding concerns. Patient daily progress notes reviewed by the inspector evidenced that nursing and medical staff continued to assess each patient's presentation and physical and mental health. Progress records also made continuous reference regarding patient insight and cognitive function.	Fully Met
3	It is recommended that the ward	1	18 (4.1)	Nurse training records reviewed by the inspector evidenced	Fully Met

	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.			that 20 of the ward's 24 nursing staff had completed up to date training in relation to safeguarding vulnerable adults. The inspector was informed that three members of staff had only recently been appointed and they would be provided with this training in the near future. One member of staff required update training. The inspector was told that this member of staff was scheduled to complete the next available training. The ward retained a safeguarding vulnerable adult information folder. The folder contained regional and Trust guidance regarding the vulnerable adult process. Staff who met with the inspector reported that they felt the Trust's vulnerable adult referral system, including the Trust's safeguarding gateway team, provided appropriate support and information regarding vulnerable adult concerns. Safeguarding vulnerable adult training for other ward professionals was overseen by their respective professional lead. The inspector was informed that other professionals on the ward continued to receive the required mandatory training in accordance to their role.	
4	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).	1	6 (Part 24)	The inspector reviewed four sets of patient care plans. Plans were noted to be hand written and based on the individually assessed needs of each patient. It was positive to note that patients had signed their care plans. The inspector evidenced that the ward's multi-disciplinary team reviewed each patient's circumstances on a weekly basis. This included a review of the patient's time off the ward. Patients could access escorted time off the ward, unescorted time and home leave. The use of locked doors within a ward is a blanket restriction. Subsequently, there should be a clear rationale	Partially Met

				as to why this restriction is necessary for each patient admitted to the ward. The inspector noted within one care plan, relating to a voluntary patient, that a rationale as to why the patient required the use of locked entrance and exit to the ward was not available. The patient had been admitted to the ward on a voluntary basis. The patient's care plan recorded that staff should aim "*To reduce as much as is practical restrictions put in place on the patient due to their status as a voluntary patient*". The care plan provided no rationale as to why the patient required that the ward's main entrance door remain locked. The inspector met with the patient. The patient reported that they did not know if they could leave the ward. The patient stated that they understood that they could discharge themselves from the ward at any time. The patient was unclear as to whether they could leave the ward to go for a walk. The patient's care plan did not record if the patient could access time off the ward to go for a walk.	
5	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.	1	17 (5.3.3)	Nurse training records reviewed by the inspector evidenced that the ward manager continued to monitor training for nursing staff. The inspector noted that 18 of the 24 nursing staff had completed up to date fire training, 20 nursing staff had completed up to date safeguarding vulnerable adult training and 18 staff had completed either intermediate life support training (qualified nursing staff) or basic life support training (unqualified nursing staff). However, the inspector noted nurse mandatory training deficits in relation to child protection training, moving and handling training, infection control training and health and safety training.	Not met

				12 staff had no record of having completed child protection training. There was no record for eight staff in relation to moving and manual handling training and there was no training record for 12 staff with regard to infection control training. The inspector was not able to evidence if any staff had completed mandatory health and safety training.	
6	It is recommended that the ward manager ensures that all staff receive training in relation to the application of the Trust's Restrictive Intervention policy.	1	6 (22)	Training records reviewed by the inspector evidenced that 12 nursing staff had completed training in relation to the application of the Trust's restrictive intervention policy on the 17 October 2013 and on the 13 November 2013. Records evidenced that 12 staff had not completed the training. The inspector was informed that further restrictive intervention policy training had been organised for the near future.	Not met
7	It is recommended that the ward manager ensures that all staff on the ward sign to verify that they have read and understand new policies introduced to the ward.	1	17 (H)	The ward manager had provided a new policy folder for staff. The folder included a staff signing sheet accompanying each policy. Staff were asked to sign the sheet to verify that they had read the policy. The staff supervision template and minutes from staff meetings evidenced that the ward's management team continued to remind staff of the importance of reviewing new policies. The inspector was informed that the ward manager continued to monitor staff adherence to this procedure. This was monitored through staff meetings and during supervision. Staff received notification as to when a new policy was available via their personal email account. The inspector noted that the policy folder evidenced that the Trust's policies in relation to supervision in nursing required review. A recommendation regarding the renewal	Fully met

				of Trust policies has been made.	
8	It is recommended that the ward manager ensures that all documentation pertaining to patient care is signed by the patient and registered nurse.	1	2 (5.13)	The inspector reviewed four sets of patient care documentation and noted that patient and staff signatures were available when required. It was good to note that in circumstances where a patient had been unable to or had refused to sign their care documentation this had been recorded.	Fully met
9	It is recommended that the trust ensures that clear thresholds and appropriate recording system be established regarding vulnerable adult referrals.	1	18 (4.1)	The Trust had introduced a safeguarding gateway team in November 2014. The team provided support to staff on the ward as required and they also managed all referrals through an electronic referral system that all staff could access. The inspector reviewed the gateway service information leaflet, a presentation regarding the service and the electronic referral system. The recording system was appropriate and it was good to note that staff who met with the inspector reported that they received acknowledgement of any referrals made/ follow up action required in a timely manner. Staff also reported that they could contact the gateway service as required for assistance and advice. The safeguarding vulnerable adult information available on the ward included advice regarding referral thresholds.	Fully met
10	It is recommended that the trust ensures that locking system for the private visiting room is reviewed	1	6 (22)	The crisis service manager informed the inspector that the locking system for the private visiting room had been reviewed. This was evidenced in the minutes of the adult mental health services client commissioning group meeting held on the 22 September 2014. The minutes recorded that the access to the visitors' room from the ward had been discussed and was unresolved at that stage. The crisis services manager advised the inspector that this had been actioned and a buzzer system	Fully met

				had been ordered and would be fitted in the near future. The system would allow patients to access the room from the ward whilst denying access from the opposite side of the door. The system had already been fitted to the other ward in the facility.	
11	It is recommended that the trust ensures that the locked door system for the ward is reviewed.	1	6 (22)	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 for the Carrick ward and this will be reviewed 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 has been made. The recommendation is stated in the quality improvement plan accompanying this report.	Fully met
12	It is recommended that the ward manager ensures that activities programmes are reviewed in partnership with the patients.	1	2 (38.1)	The ward's weekly activity planner was posted on the ward's main notice board located in the dining area. The planner was up to date and recorded the activities available to patients each day. Minutes from previous patient /staff meetings evidenced that the ward's activity programme was discussed by patients and staff on a regular basis. Action steps from the meetings included the implementation of patient suggestions and requests regarding the ward's activities	Fully met

				programmes.	
13	It is recommended that the ward manager ensures that all meetings with patients are recorded and minutes include details of issues raised, action taken, out-comes and a list of attendees.	1	12	The ward's patient/staff meeting was convened every Sunday afternoon. The inspector reviewed the records from previous meetings and noted that meetings had been held on a regular basis and had been well attended. Minutes from previous meetings evidenced: names of the attendees; a review of the outcomes from previous action steps; issues raised in the meeting; the action steps to be taken and a timeline for the completion of agreed actions. Patients who met with the inspector reported no concerns regarding their ability to access support from staff. Patients also reflected awareness and understanding of the patient/staff meeting.	Fully met
14	It is recommended that the trust ensures that the policy for handling of patient's money is reviewed to include guidance to staff managing social skills money.	1	4 (Part 2)	The ward manager had addressed the issue regarding guidance for managing social skills money through an email forwarded to the Trust's finance department on the 29 August 2013. The finance department responded and detailed that in accordance to section 1.2 of the Trust's cash handling procedures the monies allocated for social skills are provided from the Trust's principal petty cash fund. The finance department informed the ward manager that social skills money should be managed in accordance to the management of petty cash procedures.	Fully met
15	It is recommended that the ward manager ensures that a list of signatories of staff who handle money and staff who have access to the code for the ward safe is recorded and maintained.	1	4 (Part 2)	The inspector reviewed the ward's policy and procedures for the management of patients' monies. Upon admission patients' property, including money was recorded in the patients' property book. Entries in the book were signed by two staff members and the patient. Patients retained their own money providing they had been assessed as having the capacity to do so. Patients	Fully met

				presenting to the ward with large sums of money were encouraged to use the hospital's cash office where a separate account could be provided. Cash office accounts were also used to support patients who lacked capacity. Monies retained by the ward on behalf of a patient were kept in the ward's safe. The inspector was informed that patients' monies were kept in the safe on occasion and the ward held no more than £20 to £30 for a patient. Patients' money held within the safe was recorded in a patients' money receipt book and in the safe contents book. Entries into both books were signed by two members of staff. The inspector reviewed the safe book and noted a daily record detailing each time the safe was opened. The inspector evidenced that the safe was checked each day and that the ward manager carried out spot checks to ensure the safe records matched the contents of the safe.	
16	It is recommended that the trust ensures that the patients' capacity is assessed regarding individual ability to keep their own property in their personal safe.	1	4 (Part 2)	On the day of the inspection the inspector was informed that all of the patients admitted to the ward had been assessed as having capacity. Subsequently, each patient could manage their personal safe located in the cupboard within their room. The inspector was advised by the deputy ward manager that in circumstances where a patient is assessed as incapable of operating their personal safe a restrictive interventions assessment and care plan is completed. The rationale for the use of the restriction is agreed with the multi-disciplinary team (MDT). This restriction is then monitored on a daily basis by nursing and medical staff and reviewed weekly by the MDT. The inspector was advised that should a patient be	Fully met

				restricted from using their safe this restriction was managed and reviewed in accordance the Trust's restrictive intervention policy and deprivation of liberty- interim guidance.	
17	It is recommended that the ward manager develops a system to ensure all staff has formal supervision meetings and appraisal in accordance with policies and procedures as a matter of urgency.	1	17 (G)	Records of nursing staff supervision and appraisal were maintained by the ward and deputy ward manager. Records evidenced that 15 of the 19 trained nursing staff had received one supervision sessions from the 1 April 2014. Four of the 15 staff had received two supervision sessions. The inspector noted that two staff had no recorded supervision dates and two staff had recently commenced their posts. The inspector was informed that in accordance to professional and Trust standards all trained nursing staff would receive two supervision sessions by the 31 March 2015. Staff appraisal records reviewed by the inspector evidenced that none of the trained nursing staff had received appraisal from 1 April 2014. The appraisal records available detailed that two members of staff had received their appraisals in March 2014.	Not met
18	It is recommended that the trust ensures that complainants are informed of the outcome of complaints.	1	18 (6.3)	The inspector reviewed complaints received by the Carrick ward from the 1 April 2013 to the 31 March 2014. The inspector noted that two complaints regarding the ward had been forwarded to the Trust. Records evidenced that in each instance the complainant had been informed of the outcome of the complaint.	Fully met
19	It is recommended that the trust updates its Datix database to include a field for recording informing relatives regarding incidents.	1	17 (4.3) (B)	The inspector reviewed the Trust's Datix incident database. The incident report template contained a field for external notification. This included a record to confirm that the patient's relatives/carer/next of kin had been contacted regarding the incident.	Fully met

20	It is recommended that the ward manager ensure that the installation of the tea/coffee boilers is completed.	1	2 (39.11)	The inspector reviewed the tea/coffee boilers and noted that these had not been installed. The inspector evidenced that a requisition order had been completed by the ward manager and forwarded to the Trust's estates department in June 2013. Whilst recognising that the ward manager had actioned this recommendation it was disappointing to note that the boilers had not been fitted. Patients could access flasks of hot water at 9.00pm and staff retained a key to the kitchen area where staff could access a hot water boiler. However, patients could not access hot water to make tea or coffee without staff support.	Not met
21	It is recommended that the trust ensures that the art-room within the occupational therapy department is made functional for patients use.	1	2 (45.64)	The inspector reviewed the art room located within the acute day care department and spoke with three members of the facilities occupational therapy (OT) team. The room was large, bright and contained numerous pieces of artwork. The art room was noted to be well equipped. A number of large tables and a range of art materials were available. OT staff who met with the inspector reported no concerns regarding the room. The inspector was told that the room was used on a daily basis by patients. Patients who met with the inspector reflected positively on the activities available within the acute day care department.	Fully met
22	It is recommended that the ward manager ensures that the blanket policy on removal of patient's cigarette lighters is reviewed.	1	16 (4.0)	Minutes from the crisis service managers' meeting held on the 5 September 2013 evidenced that the blanket policy on removal of patient lighters had been reviewed. The minutes recorded that during the review patients on the	Fully met

				Carrick ward were consulted and reported to be in agreement that all lighters should be removed. The inspector was informed that patients had indicated that the removal of lighters and matches would make them feel safer. The review recommended no change to the blanket policy. The inspector was informed that the hospital had introduced a smoke free policy. The policy had been introduced to the Carrick ward. Patients on the ward had been informed that smoking was no longer permitted. Patients were asked not to bring lighters or matches onto the ward and staff no longer retained lighters, or provided a light to patients choosing to smoke.	

Follow-up on recommendations made following the unannounced inspection on 12 February 2014

No.	Reference.	Recommendations	No. of times stated	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
23	6	It is recommended that the Carrick ward implement patient care plans in accordance to regional guidance. This should include adherence to the Deprivation of Liberty Standards	1	Care plans reviewed by the inspector were hand written and based on the individually assessed needs of each patient. It was positive to note that patients had signed their care plans. Patients who met with the inspector reported that they had been involved in their care and treatment. Care plans detailing the use of restrictive practices were available. The inspector reviewed care plans in relation to the ward's swiped/locked door access. These care plans had been completed with voluntary and detained patients. The plans reviewed by the inspector evidenced that consideration had been given to the impact of this restriction on the patient. However, the plans did not provide a rationale as to why the patient required the use of a locked door. The plans also failed	Partially met

				to specify the patient's status in relation to time off the ward. The inspector noted that patients could access time off the ward depending on their assessed needs and the associated risk. This was evidenced in multi-disciplinary care plan reviews and on the ward's patient information smart board. This was not reflected in the care plans reviewed by the inspector.	
24	2	It is recommended that the ward manager ensures that all nursing staff complete up to date child protection training in accordance with the Trust's mandatory training standards.	1	The inspector reviewed the ward's nursing staff training records. Training records evidenced that eight staff had completed up to date child protection training. 12 staff had not completed up to date child protection training. Four staff had not completed training as they had only recently commenced working on the ward. The inspector was informed that staff requiring refresher training would be attending training in the near future.	Not met
25	2	It is recommended that the ward manager reviews patient and staff access to the ward kitchen from the hours of 6.00pm onwards.	1	The inspector was informed that nursing staff retained a key to the kitchen area. Staff could access the kitchen as required to retrieve hot water. Staff informed the inspector that they could not remain in or use the kitchen to prepare food in accordance with health and hygiene legislation.	Fully met

Follow-up on recommendations made following the patient experience interview inspection on 9 April 2014

Appendix 1

No.	Reference.	Recommendations	No. of times stated	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
26	5.3	It is recommended the ward manager ensures patients on the ward can access fluids when required.	1	The inspector reviewed the availability of fluids for patients. Patients could access a water fountain located opposite the ward's kitchen. The ward also provided a drinks machine from which patients could purchase soft drinks. Patients who met with the inspector reported no concerns regarding their ability to access fluids.	Fully met
27	5.3	It is recommended the trust review the choice and availability of food for patients on the ward. This review should consider the specific requests made by the patients.	1	The Trust had introduced a new system to facilitate patient menu choice. The Saffon ward entry system provided patients with the choice to select their meals. The system was operated from a hand held computer. The computer displayed patient menu choices and patients could select the meal they wanted by touching the screen. The computer was provided to each patient on a daily basis. It was good to note that a variety of meals were available including meals specific to lifestyle and cultural requirements. Patients who met with the inspector were complimentary regarding the quality and choice of food available.	Fully met
28	6.3	It is recommended that information in relation to the availability of chaplaincy services is displayed on the ward	1	Information regarding chaplaincy services was displayed on the ward's main notice board and in the patient induction pack. Patients who met with the inspector reported no concerns in relation to their ability to access support in accordance to their religious beliefs.	Fully met

Appendix 1

Follow-up on recommendations made at the finance inspection on 8 January 2014

No.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
29	It is recommended that the ward manager develops a system to ensure that any money given to the ward for use by patients is appropriately recorded and receipted.	The ward manager had introduced a social skills monies receipt book. The inspector reviewed the book and noted that records regarding the expenditure of money for patient use was documented and receipted. This included the availability of two staff signatures and records of ongoing audit by the ward manager. The inspector was informed that the retaining and use of social skills monies was completed in accordance to Trust finance policy and procedure. This included continued audit of monies received and expenditure.	Fully met
30	It is recommended that the ward manager ensures that appropriate systems are put in place to record purchases made by staff on behalf of patients with related receipts. Appropriate, detailed and verified records of transactions must be maintained.	The ward manager had introduced a patient receipt book to record purchases made by staff on behalf of patients. The receipt book recorded patient signatures when money was given to a staff member and when change was returned. The receipt book also contained a shop receipt evidencing the item(s) purchased.	Fully met

Quality Improvement Plan

Unannounced Inspection

Carrick Male Ward, Grangewood Hospital

24 and 25 February 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 deputy ward manager, the acute crisis service manager and the head of crisis services and lead nurse 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 6.3.2 (a)	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	Immediate and ongoing	Use and application of restrictive intervention care plans was discussed at the staff meeting on 08/04/15 and changes to ho we apply and review these was agreed. The patient Induction Package was also updated on 08/04/15. The Charge Nurse will provide a training session to staff in relation to the application of the Trust's Restrictive Intervention Policy before 30/04/15
2	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.	2	Immediate and ongoing	A training plan is already in use in conjunction with a mandatory training plan which is updated on a three monthly basis. Gaps have been identified and a plan to address the deficits is in place.
3	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 Trust's Restrictive Intervention policy.	2	31 May 2015	The Charge Nurse will provide a training session to staff in relation to the application of the Trust's Restrictive Intervention Policy before 30/04/15
4	Section 5.3.3 (d)	It is recommended that the ward manager develops a system to ensure all staff has formal	2	Immediate and	Appraisal for all staff for the 2015-2016 year has already begun and a plan is in place to ensure all staff receive

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
		supervision meetings and appraisal in accordance with policies and procedures as a matter of urgency.		ongoing	appraisal in accordance with the Trust's Policy. The Charge Nurse has identified further staff for Supervision for Supervisors Training to take place 12-14th May 2015 to replace supervisors who have recently left the service. The system for supervision in Carrick has been reviewed and an updated system is now in place.
5	Section 5.3.1 (f)	It is recommended that the ward manager ensure that the installation of the tea/coffee boilers is completed.	2	30 June 2015	The Charge Nurse has raised the issue of the installation of the water boilers with the appropriate personnel within the Directorate and is currently awaiting a timescale for completion of the work.
6	Section 5.3.1 (a)	It is recommended that the Carrick ward implement patient care plans in accordance to regional guidance. This should include adherence to the Deprivation of Liberty Standards	2	Immediate and ongoing	Use and application of restrictive intervention care plans was discussed at the staff meeting on 08/04/15 and changes to how we apply and review these were agreed.
7	Section 5.3.3 (c)	It is recommended that the ward manager ensures that all nursing staff complete up to date child protection training in accordance with the Trust's mandatory training standards.	2	30 June 2015	All Nursing Staff without up to date Child Protection Training have been booked on available training courses. All staff will have received this training by 30/06/15

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
8	Section 5.3.1(a)	It is recommended that the ward manager ensures that patient initial assessments are completed in full including the patient details section.	1	Immediate and ongoing	This recommendation was discussed at the staff meeting of 08/04/15. A new audit tool is currently being designed to audit compliance with this. It is envisaged that this audit tool will be in use at the end of April 2015.
9	Section 5.3.3 (b)	It is recommended that the multi-disciplinary team ensures that patients are kept informed of their circumstances in relation to time off the ward. The patient's leave status should be recorded in their nursing and multi-disciplinary care plans.	1	Immediate and ongoing	This recommendation was discussed at the staff meeting of 08/04/15 and changes made to the process of how nursing staff record time off the ward in the Integrated Care Pathway. The recommendation will be discussed at the Crisis Team Meeting due to take place on 21/04/15 in relation to how the whole Multi Disciplinary Team deals with the issue of time off the ward and how this is recorded. The Patient Induction Pack has also been updated to inform patients of the process in relation to time off the ward.
10	Section 5.3.1 (c)	It is recommended that the Trust reviews its swipe/locked door protocols. RQIA should be informed of the outcome of the review.	1	31 July 2015	A cross-directorate group has commenced work on the development of a Trust Policy in relation to locked doors and controlled environments. The management team for Carrick ward will conduct a review of swipe/locked door protocols in the ward and will

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
					inform the RQIA of the outcome by 31st July 2015.
11	Section 5.3.3 (f)	It is recommended that the Trust oversees the availability of psychotherapeutic interventions to ensure that patients on the ward have access to the full range of evidence based therapeutic interventions to meet presenting needs.	1	Immediate and ongoing	A range of psychotherapeutic interventions is available to patients on the ward. Staff utilise a range of therapeutic interventions such as Dialectic Behaviour Therapy (DBT), Chain Analysis, Solution Focused Problem Solving Techniques, Safety Planning and Positive Action Planning. Some staff are currently undergoing CBT training and Motivational Interviewing training. These approaches are backed up by additional training sessions for staff in DBT and Personality Disorder. Referrals are made where appropriate to the Psychological Therapy Service and the Personality Disorder Service. The Personality Disorder Service has good links with the ward and become involved on request to help develop and review treatment options and approaches for individual patients.
12	Section 5.3.3 (a)	It is recommended that the crisis service reviews and updates the patient information pack. The updated pack should include	1	30 June 2015	The Patient Induction Pack has been updated. A final meeting of the sub group who were reviewing the induction pack, including service users and their representatives, will

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
		reference to the ward's current status, use of restrictive practices and patients' rights.			take place prior to 30/06/15 to sign off on the pack.
13	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	30 April 2015	All incidents of physical intervention that occur on Carrick Ward are recorded in-line with WHSCT incident reporting policy and procedure through the DATIX system. The development and introduction of a physical intervention record and associated syatems and processes will be taken forward as a corporate matter through the adult mental health governance group for the attention of Trust Quality & Safety Sub-committee.
14	Section 4.3 (b)	It is recommended that the Trust ensures that policies and procedures requiring renewal are updated.	1	Immediate and ongoing	This matter is on the agenda for Trust Quality & Standards Sub-committee and will be taken forward in this context.

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		**Yes**	**No**	**Inspector**	**Date**
A.	Quality Improvement Plan response assessed by inspector as acceptable	x		Alan Guthrie	21 April 2015
B.	Further information requested from provider				