The Regulation and Quality Improvement Authority

RQIA

Mental Health and Learning Disability

Announced Inspection

Carrick 1

Holywell Hospital

Northern Health & Social Care Trust

25 & 26 February 2014

npm national preventive mechanism

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

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1.0 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).

1.1 Purpose of the Inspection

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

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

- The Mental Health (Northern Ireland) Order 1986;
- 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.

1.2 Methods/Process

Committed to a culture of learning, 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 the previous inspection on 24 and 25 May 2011 were also assessed during this inspection to determine the Trust's progress towards compliance. The inspector found compliance in the following areas:

- advocacy services were available to all patients and the advocate visited the ward on a regular basis;
- patients who met with the inspector detailed that they had been informed of the ward's comments and complaints process;
- the patient information booklet was available and contained appropriate information;
- care plans were developed from the assessed needs of patients and reviewed weekly by nursing staff and the multi-disciplinary team;
- the multi-disciplinary team meeting minutes reflected comprehensive review of patient progress and detailed that patients were offered the choice to attend the meeting;
- the ward's showers had been replaced;
- the therapeutic programme had been reviewed in July 2013 and continued to be monitored by the staff team.

One recommendation remained outstanding and has been restated for a second time.

An overall summary of the ward's performance against the human rights theme of Protection is in Section 3 and full details of the inspection findings are outlined in Appendix 1.

2.0 Ward Profile

Trust	Northern Health & Social Care Trust
Name of hospital/facility	Carrick 1, Holywell Hospital
Address	60 Steeple Road Antrim
Telephone number	02894413369
Person-in-charge on day of inspection	Mary O'Neill
Email address	Manager.Carrick1@northerntrust.hscni.net
Nature of service - MH/LD	Mental Health
Name of ward/s and category of care	Inpatient Addiction Treatment service
Number of patients and occupancy level on days of inspection	8
Number of detained patients on day of inspection	N/A
Date of last inspection	24 and 25 May 2011
Name of inspector	Alan Guthrie

Carrick one is a ten bedded inpatient addiction treatment service situated within the main building of Holywell psychiatric hospital. It is a mixed gender ward that provides treatment and care to patients with alcohol and or drug problems. The service provides a range of treatments including alcohol/drug detoxification, opiate substitute therapy and opiate stabilisation treatment. The ward also provides a daily psycho-social programme. Patients remain on the ward for approximately two weeks

3.0 Inspection Summary

An announced inspection of Carrick one was undertaken on 25 and 26 February 2014. The purpose of this inspection was to assess the ward's arrangements and procedures for safeguarding vulnerable adults.

The following is a summary of the inspection findings of the arrangements for safeguarding vulnerable adults on this ward and represents the position on the ward on the day of the inspection.

The ward provided a range of clinical treatments for patients suffering from addiction including detoxification from alcohol and or drugs, opiate substitute treatment and opiate stabilisation treatment. Clinical treatment interventions were supported by a psychosocial programme which recommenced every two weeks to coincide with the admission of new patients. The ward was managed by a ward manager and assistant ward manager and supported by a consultant psychiatrist, a specialist Doctor, a social worker, seven staff nurses, six mental health support workers and support staff. The ward was also supported by a physiotherapist, psychology services, a pharmacist, a group therapist, an advocate and a range of community and voluntary services.

Patients who met with the inspector detailed that they felt safe and supported and staff were helpful. The inspector noted the ward provided patients with a number of information points and a wide range of information leaflets and posters. The ward was also supported by an independent advocate whom patients could contact as required. The ward was clean, bright and maintained to an appropriate standard. However, patient access to the garden required review and the bedroom carpets and dining room floor needed to be replaced. It was also noted that the ventilation system in the toilet beside the patient assessment/admission room required repair. Recommendations have been made.

The inspector reviewed five sets of patient notes. Patient files contained up to date risk assessments, a nursing assessment, nursing care plan(s) and complementary assessment tools. Patients' care records were generally completed to an appropriate standard. However, one Malnutrition Universal Screening Tool (MUST) assessment commenced at the beginning of a patient's admission had not been reviewed as required. A recommendation that the ward manager reviews the use of MUST assessments and ensures that they are completed appropriately has been made.

The ward's protection of vulnerable adult (VA) procedure was displayed on a notice board in the ward's main office and copies of the Trust policy were also available. The inspector was informed that the ward's original designated officer (DO) had changed job and an interim DO had been appointed. The inspector noted that two VA referrals had been completed by ward staff in December 2013. The inspector was unable to find any record of communication from the DO to acknowledge receipt of the referrals or to specify if further action was necessary. Subsequently, the referrals had not

been managed by the DO in accordance with VA policy and procedure. A recommendation has been made.

The ward's two week psychosocial programme included group work sessions which were held daily Monday to Friday. The programme included art classes, gym sessions, visits from outside speakers and daily walks. Patients who met with the inspector detailed that they felt the ward provided opportunities to engage in activities and group work sessions. However, two patients expressed concerns that the art therapy classes were too simplistic. The inspector was also informed that the ward did not have continued protected support from an occupational therapist. Recommendations to review access to occupational therapy and to review the art therapy group have been made.

The ward's arrangements for ensuring the security of patient's valuables and property were discussed in the patients' information booklet. Arrangements included the use of a patient property book and the hospital's finance department. The inspector reviewed the property book and the records detailing patient contact with the hospital cash office. The property book and accounts records were completed appropriately and in accordance with Trust policy and procedure. Patients who met with the inspector reported no concerns regarding their valuables or personal belongings. The inspector noted that patients did not have access to personal lockable storage. A recommendation has been made.

The ward's training records detailed the names of each member of the nursing team and the training they had completed. On reviewing the training records the inspector found staff training deficits in relation to cardiopulmonary resuscitation (CPR) training, child protection training, fire training and moving and handling training. The numbers of staff who had completed fire training (46%), CPR (40%) and moving and handling (59%) were not sufficient to ensuring an appropriate response from staff in the event of fire, or emergency. The inspector was informed that training deficits had been prioritised. However, records did not detail a timetable to indicate when staff would complete the required mandatory training. A recommendation that nursing staff complete the required mandatory training has been restated for a second time.

The inspector was concerned that 12 (79%) members of the nursing staff team had received no training in relation to safeguarding children. A recommendation that all nursing staff complete safeguarding children training has been made.

On this occasion Carrick one has achieved an overall compliance level of substantially compliant in relation to the human rights inspection theme "Protection".

Inspectors would like to thank the patients, staff, relatives and visiting professionals for their cooperation throughout the inspection process.

4.0 Follow-up on Previous Issues

No.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	It is recommended that the input of the Advocate is reviewed and service provision is formally agreed.	The ward was supported by an independent advocate who visited once every two weeks and as required. The ward provided information about the advocacy service within the patient information booklet and on notice boards throughout the ward.	Fully met
2	It is recommended that informal complaints are documented as per Trust policy. It is recommended that community meeting minutes are recorded and clearly identify any comments or complaints raised and action taken. It is recommended that the use of patient satisfaction surveys is reviewed and responsibility for dealing with the questionnaires is allocated appropriately	The ward's complaint book evidenced that complaints by patients were appropriately recorded including the actions taken to resolve the complaint. In the absence of a local resolution the Trust's complaints procedure was clearly displayed within the ward and in the patient's information booklet. Minutes from the community meetings detailed that patient comments and complaints were discussed. Patients who met with the inspector stated that they knew who to talk to if they were not happy. Patients who relayed that they had approached staff regarding their concerns stated that action had been taken to address the concern albeit the patient did not always agree with the outcome. A patient satisfaction questionnaire was given to	Fully met

		each patient prior to their discharge. Completed questionnaires were managed and collated by the addiction service psychology staff.	
3	It is recommended that the draft relatives and patients booklets are made available to patients immediately.	The patient information booklet was available to patients and relatives. Patients who met with the inspector detailed that they had received a copy of the booklet. The booklet was appropriately detailed.	Fully met
4	It is recommended that nursing staff review the formulation of care plans and ensure that progress in relation to identified goals are clearly recorded.	The inspector reviewed five sets of patient care records. Care plans contained clinical and psychosocial interventions and these were supported by the patient's assessment. Care plans were reviewed weekly and patient progress was recorded.	Fully met
5	It is recommended that a proforma is developed to record the multi-disciplinary team (MDT) meeting to include: persons present, presentation of patients views, input from other agencies, progress of patient and changes to care plans, inform patient of outcomes. It is recommended that patients are offered the choice to attend the meeting.	The MDT proforma recorded the names of persons present, patient's views, patient progress and information regarding the patient's treatment and care pathway. Patients were offered the choice to attend the meeting.	Fully met
6.	It is recommended that one to one interventions with the named nurse are clearly recorded in case notes.	Patients who met with the inspector reported no concerns regarding their ability to speak with nursing staff on a one to one basis. Patient care records detailed that patients spoke with their named nurse on a regular basis.	Fully met

7.	It is recommended that patients are given a copy of the discharge summary to include personal relapse indicators and coping mechanisms.	The inspector was informed that discharge summaries were given to each patient prior to their leaving the ward. The discharge summary proforma contained a number of sections including the management of risk and relapse indicators.	Fully met
8.	It is recommended that progress notes should specify interventions taken, progress made and reflect the objectives documented in the care plans. It is recommended that documentation is reviewed and consideration given to maintaining full multidisciplinary case notes.	Patient continuous notes and care plans detailed that patient care plans were reviewed on a weekly basis. Reviews specified patient progress and reflected on the patient's treatment goals. There was one set of multi-disciplinary notes for each patient.	Fully met
9.	It is recommended that showers are replaced urgently and that RQIA are informed of the timeframe for this work.	Showers had been replaced and were of a good standard.	Fully met

10.	It is recommended that the therapeutic programme is regularly re- evaluated by an independent facilitator and action taken to vary existing sessions if indicated. It is recommended that all staff who facilitate groups can evidence appropriate knowledge and skills.	The ward's therapeutic programme was re-evaluated in July 2013. The inspector was informed that the programme was continually reviewed by the staff team. Staff who met with the inspector relayed no concerns regarding their participation and facilitation of group work. The staff team could also access a group work review session facilitated by a group psychotherapist.	Fully met
11.	It is recommended that a training needs analysis is completed and that mandatory training is up to date.	Training records detailed that a number of the nursing staff team had not completed their required mandatory training.	Not met

5.0 Stakeholder Engagement

Questionnaires were issued to staff, patients, relatives/carers and visiting professionals in advance of the inspection. The responses from the questionnaires were used to inform the inspection process.

Questionnaires issued to	Number issued	Number returned
Staff	20	11

During the inspection the inspector has the opportunity to meet with staff, patients, and relatives/carers, visiting professionals or advocates. Below are the details of the number of discussions held during the inspection.

Additional discussions during inspection	Number
Patients	6
Carers/Relatives	0
Visiting Professionals	0
Staff	6
Advocates	0

The following information is a summary of feedback received from those who returned a questionnaire or met with an inspector during the inspection.

Patients: Patients who met with the inspector detailed:

“Staff treat me well”;

“You’re not judged”;

“Two weeks is too short”;

“I think colouring in is too childish” (comment regarding art therapy);

“More access to the gym”;

“My partner couldn’t get in because it was medication time”;

“Staff are very good…they treat everyone equally”.

Carers/ Relatives: No carers or relatives were available to meet with the inspector.

Visiting professionals: No visiting professionals were available to meet with the inspector. Visiting professionals who completed questionnaires commented:

“Carrick one staff are very motivated and hardworking”;

“There is always a friendly atmosphere and many clients have commented on the excellent care they have received”.

Staff: Staff who met with the inspector detailed:

“Great staff team…great place to work”;

“I enjoy working here”;

“Very little funding available for the art therapy group”;

“This is a positive environment to work in”;

Advocates: The advocate was not available to meet with the inspector.

6.0 Additional Concerns Noted by Inspectors

The inspector noted a number of additional concerns:

1. Ligature risk assessment

   The inspector was informed that a ligature risk assessment had been previously completed and the ward's ligature risks continued to be monitored by the Trust. However, the inspector noted that the ward's Huntleigh beds and some door handles required a further ligature assessment. A recommendation has been made.

2. Access to the ward's garden area

   To gain access to the garden area patients were required to use three steps. Subsequently, if a patient had mobility problems or required the use of a wheelchair access would be much more difficult. A recommendation to review access to the garden has been made.

3. Bedroom carpets and dining room floor

   The carpet in the three single bedrooms and one double room needed to be replaced. The dining room flooring had one large hole and a number of worn areas and also required replacement.

4. Patients' toilet situated beside the admission/assessment room

   An odour was noted in the toilet on both days of the inspection. Further examination revealed that the toilet ventilation fans were not working. A recommendation has been made.

5. Patients' phone

   The patients' phone was located in the main corridor and patients were unable to make personal phone calls in private without the support of staff. A recommendation to review the location of the patients' phone has been made.

7.0 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.

8.0 Summary of Compliance – RQIA Assessment

No.	Question	Compliant	Substantially Compliant	Moving Towards Compliance	Not Compliant	Unlikely to become compliant	Not Applicable
1	The ward has robust arrangements in place that ensure the safety and well-being of patients that are consistent with legislative and best practice guidance documents.			✓			
2	Patients' needs are accurately assessed, risks identified and responded to appropriately.		✓				
3	The ward safeguards patient rights in relation to the use of: (i) restrictive practice; (ii) isolation/seclusion; (iii) close observation; (iv) use of restraint	✓					
4	The ward provides patients with an appropriate range of therapeutic individualised and group activities.		✓				
5	The ward has robust processes in place to ensure the safety of patients' monies and property.		✓				
6	There are procedures in place for the effective management, support, supervision and training of staff.			✓			
7	There is an appropriate organisational structure for the ward that defines staff and management roles, responsibilities and the accountability arrangements.	✓					
8	Patients and their family/carers have access to appropriate information in relation to their rights, including information on how to make a complaint.	✓					
9	Care plans are written in an individualised and person-centred manner that is consistent with professional and legislative requirements.	✓					

10	Staff report accidents, incidents and serious adverse incidents in accordance with policies and procedures and regional guidance and follow these up appropriately.	✓					

Inspection Standards – The organisation has appropriately trained staff and robust procedures to support and meet the needs of patients Ward Self-Assessment	
Statement 1. – **The ward has robust arrangements in place that ensure the safety and well-being of patients that are consistent with legislative and best practice guidance documents;** **The ward monitors these arrangements to ensure that they are appropriately and consistently applied;** **Staff ensure that vulnerable adult procedures are followed and all vulnerable adult issues are addressed promptly, appropriately and in accordance with local and regional policies and procedures.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
Carrick1 has robust arrangements in place that ensure the safety and well-being of patient's. Staff in Carrick 1 have a good knowledge base in working with patients with addiction. All staff are aware of the Operational Policy files maintained on the ward, and all staff have access to the Policy via the intranet. Staff are required to ensure all mandatory training is kept up to date. We have staff trained in Nalexone training for patient's and administration of intravenous drugs i.e. Pabrinex. Two staff trained as Infection Control link nurses. All newly trained staff on rotation to the ward have a preceptor and have access to induction courses. Risk assessments are in place for all patient's and action taken where necessary e.g. Vulnerable Adults and Child Care Issues. Vulnerable Adult Procedures/Policy and Childcare Procedures available on the ward. All staff are aware of the responsibilities regarding recording and reporting same. All staff have training in Vulnerable Adult.	Compliant
Inspection Findings: FOR RQIA INSPECTORS USE Only	
Patients who met with the inspector presented as relaxed and detailed that they felt safe and supported. Patients described the staff team as being approachable, non-judgemental and helpful. The ward's environment was bright, airy and spacious. However, the inspector noted that access to the garden required review, the bedroom carpets and the ward's dining room floor required replacement and the ventilation system in the toilet beside the patient assessment/admission room required repair. Recommendations have been made.	Moving towards compliance

The ward provided a number of interventions for patients. Treatments available included alcohol and opiate detoxification, motivational therapy and opiate substitution therapy. The ward provided treatment on an inpatient basis. The clinical treatment programmes also involved patient participation in a two week psychosocial programme. The ward's vulnerable adult's procedures were available on the notice board in the ward's main office. There were also copies of the vulnerable adult policy accessible in the ward's safeguarding vulnerable adult's folder. The inspector was informed that the ward's original Designated Officer (DO) had changed job and an interim DO had been appointed. The inspector noted that the two VA referrals had been completed by ward staff in December 2013 and these referrals had not been dealt with by the DO in accordance with VA procedures. A recommendation has been made.	

Inspection Standards – Assessment of need and risk Ward Self-Assessment	
Statement 2. – **Patients' needs are accurately assessed; risks identified and responded to appropriately.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
The Trust Addiction Service operates Stepped Care Model of Treatment which means patient's admitted to Carrick 1 for treatment programme will have already undergone a community based assessment and risk assessment. The assessment and risk assessment undertaken is discussed in the multi-disciplinary team meetings held weekly in the relevant community service which Carrick 1 Ward Manager attends. On admission ward staff update the assessment and risk assessment. Their needs are assessed and risks identified. Patient's withdrawals are monitored using CIWA/COWS scales. If there are risks and needs identified in physical health they are regularly transferred for assessment to a general hospital. Childcare issues addressed. If needs identified patients are linked to other discipline – dietician/physiotherapist/dentist/Citizen Advice is available to help with housing or benefit needs along with a Social Worker. There is a weekly ward base MDT meeting on a Thursday where patients are discussed and seen. Treatment plan and risk assessment is reviewed. The daily handovers to staff and discussion with medical staff and social worker to facilitate on-going assessment and risk. Any other disciplines involved in the patient's care will be invited to the ward to update risks.	Compliant
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
The inspector reviewed five sets of patient notes. Patient files combined the patient's community notes and their inpatient treatment notes. Subsequently, ward staff had access to details regarding the patient's contact with the community addiction team prior to their admission to the ward. Patient files contained up to date risk assessments, a nursing assessment, nursing care plan(s), supportive assessment tools (MUST assessments, an individual fire evacuation plan, infection prevention and control admission risk assessment form, a patient contract, a discharge plan) and comprehensive continuation notes. The inspector noted that patient assessments and care plans completed by the community opiate addiction service were not available. The inspector was informed that patient comprehensive assessment and care plans were retained by the opiate addiction service. The inspector was assured that ward staff could access	Substantially compliant

this information as required. The inspector was concerned that one MUST assessment completed at the beginning of a patient's admission had not been reviewed as required. A recommendation that the ward manager reviews the use of MUST assessments and ensures that they are completed appropriately has been made.	

Inspection Standards – Awareness and application of safeguarding procedures Ward Self-Assessment	
Statement 3. –The ward safeguards patient rights in relation to the use of: **(i) Restrictive Practice;** **(ii) Isolation/Seclusion;** **(iii) Close Observation;** **(iv) Use of Restraint.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
All patients in Carrick 1 are voluntary. The door to Carrick 1 is locked from the outside but opens from the inside. Prior to admission during community assessment patients are given information booklets which include patient signed agreement – which informs them of visiting restrictions, mobile phone not allowed. All patients then sign the patient agreement upon admission asking them to comply with restrictions i.e. Visiting Policy, informed ward based unless escorted by member of staff. Mobile phones are not allowed. Public phone is available. Community meeting weekly – all above is again discussed. All patients are encouraged to attend Advocacy Meeting or speak to Advocate on 1 to 1 if need to. Isolation/seclusion not applicable on the ward. Use of restraint is not applicable on the ward. All staff do have MAPA training and receive yearly update.	Compliant
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
The ward's patient information booklet explained patient and ward expectations upon admission and the rules to which each patient was asked to adhere to. Ward rules included abstinence from illicit and non-prescribed drugs and alcohol. The booklet also detailed patients were not permitted to use or retain their mobile phones, personal computers or pagers. Patients were also restricted from leaving the ward unless accompanied by a member of staff. Patients who met with the inspector reported that they had been made aware of the ward's ethos, culture and rules prior to their admission. Patients detailed that they had agreed and consented to restrictions being placed on their use of phones and their movements outside the ward. One patient detailed that they had felt aggrieved as they had not been given permission to attend a funeral. The patient relayed that staff had explained to him the reasons why	Compliant

he was not given permission to leave the ward including staff concerns regarding the potential for him to relapse. The patient stated that having considered his options he had chosen to remain on the ward. The inspector was informed that each patient had signed a patient contract agreeing to adhere to the ward's rules. A signed copy of the contract was available in each patient file reviewed. The ward did not use isolation/seclusion or restraint interventions and this was confirmed by patients and staff who met with the inspector. The ward did not use close observations and patients were cared for and monitored under general observation protocols.	

Inspection Standards – Provision of and access to therapeutic activity Ward Self-Assessment	
Statement 4. – **The ward provides patients with an appropriate range of therapeutic individualised and group activities;** **The daily programme with details of professionals involved is available and accessible;** **Clear and accurate documentation is maintained.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
As already outlined patients have already engaged in a community based treatment, programme at time of admission to Carrick 1. As part of preparation patients are given an information booklet which outlines the treatment programme and group activities – 2 week programme. Patients in Carrick 1 are involved in detoxification/stabilization treatment and group activities. Detox and stabilisation monitored using scales to observe withdrawals i.e. COWS, CIWA. Patients are seen regularly, treatment plan reviewed daily 1 to 1 face to face contact with medical, nursing and social worker. These contacts are documented clearly in patient's integrated case notes using colour codes for each discipline. Patients attend groups twice daily on the ward. The 2 weekly group programme displayed on notice board. White board updated daily informing patients of the days programme and staff on duty. Documentation kept on each group. Patients also have access to outside speakers. AA group and NA group once a week. Hope Centre speaker comes once a month. Recreational activities daily walks and twice weekly to the gym. Other recreational activities are available outdoors depending on weather, gardening and planting seeds and herbs. Recent green gym project.	Compliant
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
The ward provided a two week physcosocial programme and patients were encouraged to attend group and activity sessions which took place twice daily. Details of the programme were available on notice boards in the ward and within the patient information booklet. The ward also provided a daily information update on a whiteboard in the ward's main corridor. The board detailed the names of staff on duty, the identity of named nurses for each patient and the activities taking place that day. The ward's two week programme included group work sessions which were held daily Monday to Friday. There was also art classes, gym sessions, visits from outside speakers and daily walks. Group work interventions	Substantially compliant

included drugs and alcohol information sessions, harm reduction strategies, individual goal setting, personal care planning and implementing and maintaining individual change. The inspector was informed that the ward had no continued and protected input from occupational therapy. Patients who met with the inspector detailed that they felt the ward provided opportunities to engage in activities and group work sessions. Two patients expressed concerns that there was not enough gym access and that the art therapy classes were too simplistic. The inspector was informed that access to the gym was limited as the hospital's one gym was shared between seven wards limiting each ward's access. Recommendations to review access to occupational therapy and to review the art therapy group have been made.	

Inspection Standards – The organisation operates effective procedures for managing patients' finances and property Ward Self-Assessment	
Statement 5. – **The ward has robust processes in place to ensure the safety of patients' monies and property.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
The policy in relation to management of patient's property is adhered to. Patient information booklet given to patient prior to admission encouraging them to bring only necessary items for their stay. On admission patient's property is recorded as per hospital policy. A property book is held at ward level for lodging valuable property i.e. mobile phones; keys and bank cards copies are kept by patient, in accounts and patients notes. Patients in Carrick 1 are personally competent in managing their own money. In some case patients may have large sums of money which they choose to lodge in accounts. Signed by two staff. Copy given to patient. There is a clothing list obtained from patient on admission. Where patients wish to retain money and valuables they are required to sign a form witnessed by staff member and kept in nursing notes. There is a notice displayed on the ward informing patients about valuables and personal responsibility.	Compliant
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
The patient information booklet advised patients not to bring valuables or large amounts of money to the ward. In the event that a patient did present with valuables or money these could be lodged in a personal account in the hospital finance department. Records of money or valuables lodged with the hospital finance department were completed by the ward staff. The inspector reviewed the patient property form and found it to have been completed in accordance with Trust policy. Upon admission patients were asked to sign an agreement stating that the patient consented to returning their valuables home or to having their valuables lodged with the hospitals finance department. Upon admission patients personal property was listed and logged in the ward's patient property book. The inspector noted that Items such as bags, clothing, shoes, cd's etc. were recorded in the property book and the entry had been signed by the patient. The entry was then counter signed and witnessed by a member of staff. A copy of the patient's property log was retained by the ward and a copy was given to the patient. The inspector was informed that patients did not have access to personal lockable storage. A recommendation has been made.	Substantially compliant

Inspection Standards – There are procedures in place for the effective management, support, supervision and training of staff. Ward Self-Assessment	
Statement 6. – **The ward has an appropriate training and development plan in place to address the training needs of all staff ;** **Records of training evidence that all staff have attended mandatory training in accordance with policies, and training plans;** **Staff have the necessary skills knowledge and competence for the role they undertake;** **All staff have formally recorded supervision meetings in accordance with policies and procedures;** **All staff have formally recorded annual performance appraisal meetings;** **Additional support is provided for staff through various mechanisms, such as regular ward meetings.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
The ward has an appropriate training and development plan in place to address the training needs of staff. Matrix of training needs is available on ward. Pink file on the ward for all staff. Mandatory training records yearly update are adhered to. Additional training has been made available on the ward to all staff e.g. Naloxone training, motivational interviewing. A pathway for development regarding support workers is available. All staff take part in yearly performance reviews where training needs are identified as well as skills and knowledge noted for competence in their role. All staff have clinical supervision in accordance with policy. There was internal audit done in hospital last September from that draft of new policy issued to be implemented. Staff meeting s is held on the ward formal-informal. A weekly supervision/reflection group is available for staff facilitated by a community Psychologist. Preceptors are available for new staff.	Substantially Compliant

Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
The ward's staff training record detailed the mandatory training completed by each member of the nursing team. Subsequently, the ward manager had clear oversight of staff training and when there was a need for refresher or further training. The inspector reviewed the ward's training record and noted training deficits in relation to cardiopulmonary resuscitation (CPR) training, child protection training, fire training and moving and handling training. The numbers of staff who had completed fire training (46%), CPR (40%) and moving and handling (59%) were not sufficient to ensuring an appropriate response from staff in the event of fire or emergency. The inspector was informed that training deficits had been prioritised. A recommendation that nursing staff complete the required mandatory training has been restated for a second time. The inspector was concerned that 12 members of the nursing staff team had received no training in relation to safeguarding children. Records reviewed by the inspector detailed that nine Unmet Needs of Children in Northern Ireland (UNOCINI) referrals had been generated by the ward during the previous year. These referrals had been completed by the ward's social worker. A recommendation that all nursing staff complete safeguarding children training has been made. Staff who met with the inspector detailed no concerns regarding their supervision sessions and their appraisal. Staff could also access a reflective practice group and a ward team meeting. Minutes from the ward team meetings detailed that meetings were held every three months. The inspector reviewed the minutes from the previous year and found them to be comprehensive. The minutes reflected that a broad range of ward and staff issues were discussed and action steps agreed. The reflective practice group was facilitated by a group psychotherapist and gave staff the opportunity to discuss and review group work, and the associated dynamics, within the ward.	Moving towards compliance

Inspection Standards – There is an appropriate organisational structure for the ward that defines staff and management roles, responsibilities and the accountability arrangements Ward Self-Assessment	
Statement 7. – **Patients and staff are aware of the organisational structure and accountability arrangements;** **Staff can describe their reporting procedures;** **Senior staff can describe their role in the accountability framework for the ward, and how/if this works in practice.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
Staff are aware of the organisational structure and accountability arrangements. Staff are aware of policy folders and policy access via intranet. Staff are aware of and can describe reporting procedures to line managers. Senior staff can describe their role in accountability framework for ward. All staff have appropriate knowledge through training, updating protocols and procedures that help them support clinical decision making. Regular staff meeting, budgeting meetings monthly with Assistant Director of Mental Health. Patients are made aware of staff structuring. Notice displayed on ward of all staff. Also made aware in patient/staff meetings. Individualised named nurse completed daily for each patient.	Compliant
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
The ward's daily staffing structure was available on the white board in the ward's main corridor. Details of the Trusts addiction services structure were also available on staff notice boards. Staff who met with the inspector relayed understanding of the ward's reporting structures and demonstrated awareness of the ward's vulnerable adult and child protection procedures. Patients stated that they would know who to talk to if they were not happy. The ward was supported by an independent advocate who visited once every two weeks and at the request of patients. Patients were invited to attend the weekly multi-disciplinary team review and all patients' were asked to complete a satisfaction questionnaire prior to their discharge. Information from questionnaires was collated by the addiction service psychologist(s) and shared with ward staff, patients, relatives and patient representatives. The ward manager attended the addiction services monthly meeting and a hospital ward manager meeting every three months. The addiction service meeting was convened to facilitate regular contact between the	Compliant

addiction services management team and to share information including the outcomes of incidents, accidents or serious adverse incidents.	

Inspection Standards – Information for patients and carers Ward Self-Assessment	
Statement 8. – **Patients and their family/carers have access to appropriate information in relation to their rights;** **There is a defined complaints procedure in place in a format appropriate to the needs of patients and their carers;** **The ward maintains appropriate records of complaints, concerns, suggestions and compliments.** **There is evidence of feedback from the Governance leads in relation to complaints and concerns raised.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
Patients and relatives have access to appropriate information in relation to their rights. As stated previously patients are involved with community addictions prior to admission. As part of the preparation for admission patients are given, Patient information booklets which include outline of Carrick 1, visiting arrangements, patients signed agreement and treatment programme. Relatives are issued with relative information booklet. Information boards are evident on the ward. There is a defined complaints procedure on the ward and all staff are aware of it. Comments/complaints book available for patients for staff to record informal complaints and action taken. Patient's attend weekly Community Meeting where issues are raised and actioned by staff. Advocacy service is available to all patients in Carrick 1, meetings are held with patients twice a month – any issues from meetings are addressed by the ward manager. Patients complete on discharge Patient Satisfaction Questionnaires. Relatives group twice a month. At ward level Carrick 1 have no feedback at present from Governance regarding complaint's/concerns raised.	Compliant.
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
The ward was supported by an independent advocate who attended once every two weeks and as required through patient request. Four of the patients who met with the inspector relayed that they understood the role of the advocate and how to contact them if required. One patient could not recall receiving any information about the advocate although the patient felt this was probably as a result of their poor physical health upon admission. The inspector noted that information regarding the advocacy service was available at several points throughout the ward. Information regarding patient rights was detailed in the patients' information booklet. Information was also	Compliant

available on the ward's main notice board. Concerns regarding inappropriate infringement on human rights were highlighted, to the inspector, by two patients. Patient's concerns related to the imposed restrictions placed on them when they left the ward or when they requested time off the ward. Although the patients' felt that the restrictions were inappropriate they stated that they had chosen to abide by the ward rules and remain on the ward as they were keen to honour their personal commitment to complete treatment. Informal complaints regarding the ward were recorded in a local complaints book. The inspector reviewed the complaints book and found that records were appropriate and completed in accordance with Trust and regional guidelines. The informal complaints procedure was supported by the Trust's formal complaints process. Information regarding the Trust's complaints procedure was available to patients through the information booklet, the ward's notice boards and from the ward advocate.	

Inspection Standards – The organisation has a clear policy for documentation and management of records, confidentiality and sharing of information. Ward Self-Assessment	
Statement 9 – **Care plans are written in an individualised and person-centred manner that is consistent with professional and legislative requirements.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
As previously stated Carrick 1 is a component of a patient treatment pathway as patients are actively involved in their treatment with the Community Addiction Service prior to admission. The assessment and treatment plan received on admission by the Multi-Disciplinary Team and care plans formulated – which reflect the treatment plan. We use Core Care Plans for detoxification/Substitute Prescribing. We also draw up Care Plans individually depending on patient's needs. All patients are supported in reading, agreeing and signing their care plans. Care plans are reviewed as necessary by MDT and patients daily, at team meetings. All staff are aware of the NMC Code of Conduct in relation to records and record keeping.	Substantially compliant.
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
The inspector reviewed five patient care plans. Nursing care plans contained both pre populated clinical care interventions and handwritten entries for each patient. Pre-populated care plans were appropriate to the clinical needs of patients and included plans that detailed detoxification from alcohol and drugs and commencement onto opiate substitute treatment. The inspector found that care plans were comprehensive and in accordance with the assessed needs of the patient. Patients who met with the inspector detailed that they had been involved in their treatment and care and they understood why they were in hospital. Patient care plans were personalised and included details regarding the patient's discharge plan and continued community support. Patient signatures were noted where required.	Compliant

Inspection Standards – The organisation has a clear policy for the reporting of accidents, incidents and serious adverse incidents Ward Self-Assessment	
Statement 10. – **Staff report accidents, incidents and serious adverse incidents in accordance with policies and procedures and regional guidance and follow up these up appropriately.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
Carrick 1 staff are all aware of the Accident/Incident book and the process of reporting same. The incident form is sent and signed by the Clinical Service Manager, then sent to the Head of Addiction Service and forwarded then to Governance Department. Serious Adverse Incidents (SAI's) are reported to Senior Management and appropriate documentation completed. Follow up procedures are followed as per Regional Guidelines. Any recurring incidents or irregularities are reviewed and learning outcomes shared with them.	Compliant
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
The inspector reviewed copies of the ward's incident and near miss reporting records. Twelve incidents/accidents had been recorded from the 22 October 2013. The inspector found that incident forms were completed in accordance with Trust policy and procedure. The incident and accident forms reviewed contained appropriate detail including the action taken by staff, when required, to prevent recurrence. Each incident form had been completed in triplicate with a copy retained in the ward, a copy forwarded to the risk management department and a copy forwarded to the head of the addiction services and quality improvement. Accidents, incidents and serious adverse incidents were also discussed at the addictions services monthly meeting which was attended by the ward manager, service manager and the head of the Trust's addiction services.	Compliant

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

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

SUPPLEMENTARY INFORMATION

For information or incidents within the last 12 months, this is interpreted as being from the date of the inspection.

Within the last 12 months, please confirm the number of Under 18 admissions to the ward and the age, gender and length of stay for each placement.							
Admission number	Age	Gender	Length of Stay (days)	Admission number	Age	Gender	Length of Stay (days)
1	NONE	-	-	8			
2				9			
3				10			
4				11			
5				12			
6				13			
7				14			

Within the last 12 months, please confirm the number of investigations undertaken on the ward and their outcomes.			
Adult Protection Investigations		**Child Protection Investigations**	
Substantiated Allegations	0	Substantiated Allegations	0
Unsubstantiated Allegations	10	Unsubstantiated Allegations	3
On-going Allegations	1	On-going Allegations	0
Total	11	Total	3

Please confirm the names of the following contacts for safeguarding children and vulnerable adults.	
The wards Nominated Manager for Safeguarding Vulnerable Adults	Designated Officer: Thomas Rush Investigating/Designated Officer: Helen Dougan

Quality Improvement Plan

Announced Inspection

Carrick One, Holywell hospital

Northern Health and Social Care Trust

25 and 26 February 2014

The issue(s) identified during this inspection are detailed in the inspection report and the Quality Improvement Plan.

The details of the Quality Improvement Plan were discussed with the ward manager, the head of the addiction service and quality improvement, the addiction services manager and the ward's social worker either during or after the inspection visit. Please refer to Appendix 1 for specific reference documents. The timescales for completion commence from the date of the inspection.

1. Recommendations restated from previous inspection

No.	Recommendation	Number of times stated	Details of action to be taken by ward/trust	Timescale
1.	It is recommended that a training needs analysis is completed and mandatory training is up to date	2	A training schedule has been developed to update all staff in mandatory training . This has been accepted by RQIA A spread sheet has been developed and this will be used by the ward manager to monitor staff attendance at mandatory training to ensure compliance with mandatory training requirements.	Immediate and ongoing.

2. Recommendations made following inspection of safeguarding vulnerable adults and children – human rights theme of protection

No.	Recommendations	Number of times stated	Document Number	Reference	Details of action to be taken by ward/trust	Timescale
	The organisation has appropriately trained staff and robust procedures to support and meet the needs of patients					
2.	It is recommended that the Designated Officer reviews all vulnerable adult referrals in accordance with regional and Trust policy and procedure.	1	19	Part 2, section 11, page 23.	Our Two Addiction Service Managers completed Designated Officer training in March 2014. All Vulnerable Adult referrals will now be reviewed by our identified Designated Officers.	Immediate and ongoing

No.	Recommendations	Number of times stated	Document Number	Reference	Details of action to be taken by ward/trust	Timescale
	Assessment of need and risk					
3.	It is recommended that the ward manager reviews the use of the Malnutrition Universal Screening Tool (MUST) and ensures that it is completed in accordance to the stated guidelines.	1	2	Section 2, standard 2, number 12.8, page 9.	Completion of the Must Tool was raised with all relevant staff at team meeting on 28/03/14. The Must Tool will be implemented in an appropriate way for our client group and reviewed weekly. The ward manager will monitor the use of the MUST Tool by undertaking a file audit on a monthly basis.	Immediate and ongoing

No.	Recommendations	Number of times stated	Document Number	Reference	Details of action to be taken by ward/trust	Timescale
	Provision and access to therapeutic activity					
4.	It is recommended that the Trust ensures that the ward has continued input from an occupational therapist.	1	2	Section 5, number 37.1, page 21.	Occupational Therapy input is being explored by the Ward Managerwith hospital OT Service Manager. Consideration of recruitment of a OT position to provide OT input in Carrick 1 is underway.	30 June 2014
5.	It is recommended that the Trust ensures that the ward's art therapy sessions are properly resourced.	1	2	Section 5, number 38.3, page 22.	At present creative art sessions are under review. We intend to explore with OT Services a range of options available through the Arts Council for patients to use creative arts within our	Immediate and ongoing

No.	Recommendations	Number of times stated	Document Number	Reference	Details of action to be taken by ward/trust	Timescale
					specific treatment programme.	
	The organisation operates effective procedures for managing patients' finances and property					
6.	It is recommended that the ward manager ensures that patients have access to personal lockable storage.	1	2	Section 4, standard 29.1, page 19.	Minor capital works has been sent to Estates on 15/04/14.	30 June 2014
	There are procedures in place for the effective management, support, supervision and training of staff.					
7.	It is recommended that all nursing staff complete child protection training in accordance to Trust mandatory training standards.	1	2	Section 1, standard 5.13, page 4	Training plan now in place. By 30/4/14 47% will be trained, by 31/5/14 80% will be trained and by the 19/6/14 100% will be trained.	31 May 2014

No.	Recommendations	Number of times stated	Document Number	Reference	Details of action to be taken by ward/trust	Timescale
	Additional Recommendations.					
8.	It is recommended that the Trust completes a ligature risk assessment of the ward to include a review of the ward's beds and door handles.	1	2	Section 4, standard 22.3, page 16	There had been an anti ligature risk assessment done on 10/7/09 and work identified by this assessment was carried out approx 3 years ago. This audit will be repeated in 2 weeks. At present there is a hospital senior management sub group already in place to look at procurement of anti ligature beds throughout the hospital.	Immediate and on-going
9.	It is recommended that the Trust reviews patient access to the ward's garden and ensures that all patients can use the garden.	1	2	Section 4, standard 33.1, page 20	Minor capital works has been raised and will progress through estates.	30 June 2014

No.	Recommendations	Number of times stated	Document Number	Reference	Details of action to be taken by ward/trust	Timescale
10.	It is recommended that the Trust replaces the carpet in the ward's three single bedrooms and one double bedroom.	1	2	Section 3, standard 18.2, page 14	Minor capital works has been completed and to be prioritised through estates.	Immediate and on-going
11.	It is recommended that the Trust replaces the ward's dining room flooring.	1	2	Section 3, standard 18.2, page 14	Minor capital works has been completed and to be prioritised through estates	Immediate and on-going
12.	It is recommended that the ward manager ensures that the extraction fan in the patients' toilet beside the admission room is repaired.	1	2	Section 4, standard 30.3, page 19	A new extractor fan was put in place on 16/4/14	Immediate and on-going
13.	It is recommended that the Trust reviews the ward's patient (public) phone and ensures that patients can make phone calls in private.	1	2	Section 4, standard 29.5, page 19	This has been forwarded to service users advocacy meetings and linked in with Estates Services to identify a solution.	30 June 2014

NAME OF WARD MANAGER COMPLETING QIP	Mary O Neill
NAME OF CHIEF EXECUTIVE / IDENTIFIED RESPONSIBLE PERSON	Paul Cummings

APPROVING QIP	

Inspector assessment of returned QIP				Inspector	Date
		Yes	No		
A.	Quality Improvement Plan response assessed by inspector as acceptable	x		Alan Guthrie	1 May 2014
B.	Further information requested from provider				

Appendix 1 – MHLD Reference Documents

MHLD Document Number	Legislation Title
1	AIMS -Older People(2009)
2	AIMS-Working Age Adults(2009)
3	AIMS-Learning Disabilities(2010)
4	Circular HSS(F)57/2009 – Residents' Monies
5	Complaints in HSC: Resolution & Learning (2009)
6	DHSSPS Interim Guidance - Deprivation of Liberty(2010)
7	DHSSPS Guidance - Restraint and Seclusion(2005)
8	Human Rights Act(1998)
9	Improving Dementia Services Reg Strategy(2011)
10	Learning Disability Service Framework(2012)
11	Mental Health(NI)Order(1986)
12	NICE Quality Standard 14-User experience(2011)
13	NICE Clinical Guideline 136 -User experience(2011)
14	OPCAT(2002)
15	Procedure for Reporting & Follow Up of SAIs(2010)
16	Promoting Quality Care(2009)
17	Quality Standards for HSC(2006)

MHLD Document Number	Legislation Title
18	Safeguarding VAs-Shared Responsibility(2010)
19	Safeguarding VAs-Protection Policy & Guidance(2006)
20	Service Framework for Mental Health & Well Being (2011)
21	UN Convention-Person with Disabilities(2006)
22	UN Convention-Rights of the Child(1989)
23	UTEC Guidance(2007)