RQIA

Mental Health and Learning Disability

Unannounced Inspection

Carrick 4

Holywell Hospital

Northern Health & Social Care Trust

27 & 28 October 2014

informing and improving health and social care
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Contents

1.0 General Information 3

2.0 Ward Profile 3

3.0 Introduction 4

3.1 Purpose and Aim of the Inspection 4

3.2 Methodology 4

4.0 Review of action plans/progress 6

4.1 Review of action plans/progress to address outcomes from the previous announced inspection 6

4.2 Review of action plans/progress to address outcomes from the previous patient experience interview inspection 6

4.3 Review of action plans/progress to address outcomes from the previous financial inspection 6

5.0 Inspection Summary 7

6.0 Consultation Process 8

7.0 Additional matters examined/additional concerns noted 9

8.0 RQIA Compliance Scale Guidance 10

Appendix 1 Follow up on previous recommendations 171

Appendix 2 Inspection Findings 11

1.0 General Information

Ward Name	Carrick 4
Trust	Northern Health & Social Care Trust
Hospital Address	Holywell Hospital 60 Steeple Road Antrim BT41 2RJ
Ward Telephone number	028 94465211
Ward Manager	John Quinn
Email address	john.quinn@northerntrust.hscni.net
Person in charge on days of inspection	Binu Vijayan
Category of Care	Mental Health
Date of last inspection and inspection type	20 May 2014, Patient Experience Interviews
Name of inspector(s)	Audrey Woods & Wendy McGregor

2.0 Ward profile

Carrick 4 is a locked ward situated on the ground floor, off the central corridor, in the main Holywell hospital building. The ward provides a psychiatric inpatient service to both female and male patients with enduring mental illness and challenging behaviours. The main purpose and function of the ward is the rehabilitation and resettlement of patients into the community. The ward is split into three separate areas. There is a male challenging behaviour unit, a separate female ward area and male ward area. The wards capacity has increased from an eight bedded ward to a sixteen bedded ward.

The multi-disciplinary team consist of two consultant psychiatrists, psychology, nursing, a medical registrar (on the ward daily), two fulltime occupational therapists and an occupational assistant, two social workers, one with a resettlement role and one ward based. Referrals can be made to Speech and language and other allied health professionals. An advocate service is also available to patients on the ward every week.

On the days of the inspection there were fifteen patients on the ward and fourteen of these patients were detained under the Mental Health (Northern

Ireland) Order 1986. There were ten patients whose discharge was considered delayed.

The ward was bright, clean and spacious. On the day of the inspection it was decorated for Halloween. Privacy for patients is ensured through the provision of single rooms with ensuite facilities. Each unit had a furnished day room and access to a garden area which was well maintained. A laundry room was available, an occupational therapy (OT) room, well equipped OT kitchen, a visitors room and toilet facilities. The nursing office is centrally located which overlooks the challenging behaviour unit.

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 inspectors would like to thank the patients and staff for their cooperation throughout the inspection process.

4.0 Review of action plans/progress

An unannounced inspection of Carrick 4 was undertaken on 27 and 28 October 2014.

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

The recommendations made following the last announced inspection on 25 and 26 June 2012 were evaluated. The inspector was pleased to note that 17 recommendations had been fully met and compliance had been achieved in the following areas:

- Advocates are now more actively supporting patients in a number of ways in Carrick 4 ward.
- Complaints are discussed daily at the staff de-briefing meetings and information on complaints is available throughout the ward and in the patient's individual handbook.
- Vulnerable adult training is now part of the wards induction programme
- Staff receive regular formal supervision sessions
- Patients are encouraged to talk to advocates from NIAMH who visit the ward each week and hold monthly patient meetings
- A record is kept of patients clothing and property and is recorded in the Integrated pathway documentation
- Staff receive UNOCIN training as per Northern Health and Social Care Trust policy.
- All patients have a physical health check when admitted onto the ward to include dental health checks, if concerns are raised patients are referred onto the dentist in the hospital site
- Patients are encouraged to give up smoking on the ward and if in agreement a referral is made to the smoking cessation practitioner
- Occupational therapy assessments are completed for each patient.
- Patients are actively encouraged to maintain their person hygiene, attend to their laundry and purchase new clothing.
- The pay phone on the ward has been moved so that patients have a private room to make calls

However, despite assurances from the Trust, one recommendation had not been met and one could not be assessed on the days of the inspection. One recommendation will require to be reassessed and one recommendation will be restated for a second time in the Quality Improvement Plan (QIP) accompanying this report.

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

The recommendations made following the patient experience interview inspection on 6 December 2013 and 20 May 2014 were evaluated. The

inspector was pleased to note that six recommendations had been fully met and compliance had been achieved in the following areas:

- Information leaflets are available on the ward in relation to the advocacy service
- The payphone has been moved so that patients can make a call in private.
- The garden areas outside are clean from any smoking debris
- Inspectors observed positive interactions between patients and staff on the ward
- Care plans are revisited with patients to ensure they understand their care and treatment plans
- Care plans are reviewed regularly by staff on the ward

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

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

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

- A system is now in place to verify clothes purchased for patients
- The Trust has reviewed the system in place in relation to the number of people authorised to withdraw monies from patients accounts
- When there are concerns raised regarding patients ability to manage their finances a capacity assessment is completed.
- The key to the safe is held by the nurse in charge of the ward. A record of who is holding the key is signed by two members of staff
- Accurate and appropriate records and receipts are maintained for monies received by patients. This is signed by two members of staff
- Records are kept of patient’s individual purchases and records are sent to the cash office to verify the patients balance.

However, despite assurances from the Trust, three recommendations had not been met and will be restated for a second time, in the Quality Improvement Plan (QIP) accompanying this report.

Details of the above findings are included in Appendix 1.

5.0 Inspection Summary

Since the last inspection, inspectors found that progress had been made in relation to the care and treatment of patients on the ward. Advocates are now more actively supporting patients on the ward by attending the ward on a weekly basis and by holding monthly meetings with the patients. Complaints are discussed daily with staff on the ward at the de-briefing meetings held in the morning. Vulnerable adult training is now part of the wards induction programme and staff receive regular formal supervision sessions

All patients have a physical health check when admitted onto the ward to include dental health checks, if concerns are raised patients are referred onto the dentist on the hospital site

Patients are encouraged to give up smoking on the ward and if in agreement a referral is made to the smoking cessation practitioner. Staff are receiving training on the various methods available to assist patients in giving up smoking.

Occupational therapy assessments were completed for each patient and there are now two occupational therapists on the ward and one occupational therapist assistant. Patients are actively encouraged to maintain their person hygiene, attend to their laundry and purchase new clothing.

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 policy on consent for examination, treatment or care September 2010 was available on the ward for staff. Inspectors spoke to four staff on the ward who demonstrated their knowledge and understanding of gaining consent to care and treatment and the process to follow if consent had not been gained. Eight out of the ten questionnaires returned indicated that staff had not received training in capacity to consent

In care documentation reviewed by the inspectors relating to four of the 15 patients on the ward, there was evidence in the patients care plans, multi-disciplinary records and progress notes that patients were given the time to understand their care and treatment and that patients were continually assessed regarding their ability to consent to care and treatment. It was documented that that staff had gained consent from patients on a daily basis, for example in order to assist patients with personal care and attend to therapeutic activities.

It was good to note there was evidence in the care documentation that when concerns had been raised regarding patients ability to manage their finances a financial capacity assessment had been completed and care plans were updated detailing the plan in place to assist the patient in managing their finances whilst on the ward.

The inspectors spoke to four patients on the ward who all stated that they had been consulted in all aspects of their care and treatment. All four patients stated that they have been involved in multi-disciplinary meetings and had felt that their views had been considered with regard to decisions about their future support needs and continual care and treatment.

Consideration to Human Rights Article 8 respect for private and family life and Article 14 right to be free from discrimination was documented in the four sets of care documentation reviewed.

All four sets of care documentation reviewed by the inspectors had a comprehensive needs assessment completed which was a detailed multi-disciplinary assessment competed by nursing, medical, social work and occupational therapists. It was good to note that all four assessments were individualised and person centred.

Four patients who spoke to the inspectors indicated that they had been involved in their assessments, care plans and review meetings. The patients spoke positively about the staff on the ward and the care and treatment they have been receiving.

Inspectors noted that the multidisciplinary Team (MDT) ward round was held each week. Each patient had the opportunity to attend and participate in a discussion regarding all aspects of their care and treatment plan at the weekly ward round. However, in one set of care documentation reviewed by the inspectors, there was no evidence that a multi-disciplinary meeting had been held for one patient since July 2014 due to the unavailability of the patient's consultant. This was also the case for another two patients on the ward on the days of the inspection. The three patients had been attended by the ward registrar.

The inspectors reviewed four sets of care documentation. Two out of the four sets of care documentation contained comprehensive risk assessments which were completed in accordance with the Promoting Quality Care- Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services May 2012. However one set of care documentation contained an assessment which was not signed by the patient and no record to indicate why the patient had not signed the document. The management plan had also been completed incorrectly. One set of care documentation had a risk screening tool completed which indicated that a comprehensive assessment needed to be completed however this was not in the care documentation.

Inspectors reviewed minutes of the daily team meeting convened each morning. It was good to note that: vulnerable adult concerns, complaints, physical interventions, infection control, accidents and incidents, patients' progress and staffing levels were discussed at these meetings. Any changes that had been agreed in relation to patients care and treatment was also discussed at this meeting to ensure continuity of care.

Inspectors noted that patient's Article 8 rights to respect for private and family life was considered in the care documentation reviewed by the inspectors

On the day of the inspection, inspectors undertook a direct observation of the ward. Inspectors noted that interactions between the staff and patients were responsive, appropriate and respectful

Inspectors reviewed care documentation relating to four patients. There was evidence that occupational therapy assessments had been carried out for all four patients and individual timetables developed from these assessments. There was evidence in the four sets of care documentation that patient's progress with regard to their mental health condition and activities of daily living was recorded by the nursing staff and the occupational therapist. On the days of the inspection two of the occupational therapist were on annual leave leaving only one occupational therapist to cover the ward. Inspectors were informed that due to this arrangement the level of activities provided by occupational therapy had been reduced on the ward.

Three of the four patients who spoke with inspectors stated they would like more activities arranged over the weekend and in the evenings.

Ward based, hospital based or community based therapeutic and recreational programmes were offered to patients and in accordance with each patient's individual need and risk assessment. The multidisciplinary team assessed each patient's mental health at all stages.

The occupational therapists on the ward completed the comprehensive needs assessments as part of the multi-disciplinary assessment for all patients on the ward.

Inspectors assessed that the patient's Human Rights article eight, the right to respect for private and family life, had been considered with regard to the therapeutic and recreational activities.

Thirteen of the fifteen patients on the ward on the days of the inspection were subject to detention under the Mental Health (Northern Ireland) Order 1986. Three of the four sets of care documentation reviewed by inspectors were patients who were detained under the Mental Health (Northern Ireland) Order 1986. Two of these patients had care plans in place which detailed that they had been given information on their rights in relation to Mental Health Review Tribunal (MHRT) and the detention process. These patients had also been given information on the advocacy service. However one patient who was detained under the Mental Health (Northern Ireland) Order 1986 had no care plan in place which detailed that they had been given information on their rights in relation to MHRT and the detention process.

Eight out of the ten questionnaires returned indicated that staff had not received training in human rights.

The Inspectors met with four patients on the ward. All four patients informed the inspectors that they had been involved in their care and treatment and had felt that the doctors and nurses had listened to them when discussing their care and treatment. All four patients were aware of the advocacy service and knew who their named nurses were. They also knew who to speak to if they needed to make a complaint. These patients were aware that they could meet with the nursing staff and the consultant to discuss their rights in relation to accepting and refusing care and treatment.

Information in relation to the complaints procedure and the advocacy service was available on the ward. This information was also recorded in the patients' individual handbook. It was good to note that two advocates from NIAMH had attended the ward on a weekly basis and had convened regular monthly meetings with the patients.

Each patient received an individual ward information handbook on admission to the ward. However there was no information in this booklet that gave patients information in relation on the detention process and the mental health review tribunal.

The four staff who met with the inspectors were aware of the role and function of the advocacy service and how to refer patients to this service.

The Northern Health and Social Care Trust Policy on Deprivation of Liberty Safeguards and Human Rights -13 August 2012 amended August 2014 was available for staff on the ward. This policy included in the Deprivation of Liberty Safeguard (DOLS) Interim Guidance 2010.

Patients' rights are continually discussed at each ward round information was available on the ward on the patient advocacy service, MHRT and the complaints procedure.

Inspectors reviewed four sets of patients care plans in relation to deprivation of liberty. Inspectors noted that these care plans were not individualised and did not detail the rationale for the restriction of patients requiring a secure ward, restriction on patient's money, fluid restrictions, physical interventions and restriction in relation to activities they take part in. There was also no acknowledgment of the patient's human right article 5 throughout the care plans.

It was good to note that eight out of the ten staff members indicated that they were aware of the Deprivation of Liberty Interim Guidance 2010. However eight out of the ten members of staff indicated they had not received training in restrictive practices.

Inspectors were informed that resettlement meetings are held every month for patients on the patient transfer list (PTL). Multi-disciplinary team resettlement meetings are held with relevant outside organisations and the patients advocate. Inspectors spoke to the social worker on the ward who is involved in resettling patients into the community who are currently on the PTL list.

The social worker discussed their role in detail and advised that all professionals are working closely together to ensure patients are placed in suitable accommodation and are provided with the appropriate level of support to meet their individual needs. Once a placement has been sourced the social worker meets with the patients to discuss the placement and to gain their views and the views of their representative if appropriate. If patients are in agreement then multi-disciplinary discharge planning meetings are held with the patients and their representatives to discuss and agree future developments and arrangements.

Inspectors spoke to four patients who discussed the options available to them with regard to their discharge. These patients were looking forward to their move into the community. One patient was currently on a phased transition to a new facility and another patient advised that professionals were looking at a supported living home for them. The patients advised they were involved in the discharge arrangements and felt staff were listening to them. They also had the support of the advocates on the ward from NIAMH

The nurse in charge stated that there were ten patients on the Carrick 4 who were assessed as delayed in their discharge from hospital and the reason for this was that there were not enough suitable placements in the community for these patients. It was good to note that there was also a social worker on the ward who is sourcing placements in the community for these patients who are not currently on the PTL.

Inspectors noted that the patient's article 8 rights to respect for private and family life was considered as part of discharge planning. This was evidenced through the involvement of the patient and their relative/carer in the care documentation.

Details of the above findings are included in Appendix 2.

On this occasion Carrick 4 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,   inspector was able to meet with:

Patients	4
Ward Staff	4
Relatives	0
Other Ward Professionals	1
Advocates	2

Patients

Inspectors spoke to four patients on the ward. All four patients stated they knew why they were in hospital and knew what they could and could not do on the ward. All four patients stated they had been involved in their care and treatment and had attended the multi-disciplinary ward rounds. The patients were all aware that there was an advocacy service on the ward; one patient informed the inspectors that one of the advocates was helping them to access medical records regarding their care and treatment. One patient who was on a phased transition into a new community facility talked about their new home and appeared very excited and happy about moving out of the hospital. They stated that they have been involved in discharge planning meetings and they were happy with the plans that have been made. All four patients stated they attend various activities such as going for walks on the hospital grounds with the nurses or the occupational therapist, going out at the weekends to see their family, going to the shops, watching television, making jewellery, relaxation classes, cookery and reading. However three out of the four patients stated they would like more activities arranged for the weekends and evenings. Patients made the following comments about their overall care and treatment on the ward: "I like the nurses", "the doctors can be strict, nurses are easier", "the occupational therapist keeps me busy", my family have been involved in my move out of hospital", "all good, staff all nice".

Relatives/Carers

This Inspection was unannounced. There were no patient relatives/carers on the ward on the days of the inspection.

Ward staff

Inspectors spoke to four members of staff on the ward. Staff discussed their role in the ward and their experience working with patients who have a mental health problem. Staff had a good knowledge of the patient's individual needs

and were able to give an update on the reasons why patients were on the ward. They were also able to advise inspectors of various proactive strategies they would use with patients when challenging behaviours were displayed. They appeared to have a good understanding of the vulnerable adult process they would follow on the ward when an incident occurs. Staff recognised there had been many changes in the ward since it had been amalgamated with other wards in the hospital. However, they were unclear of the overall function of the ward. They stated in can be a challenge staffing three different areas within one unit. Staff indicated that they enjoyed working on the ward and they felt that staff supported each other on the ward

Other Ward Professionals

Staff spoke to the resettlement officer on the ward who is involved in ensuring that patients are placed in suitable accommodation in the community. This staff member advised that multi-disciplinary meetings are held on a regular basis to discuss and plan what needs to take place for patients to make a successful move into the community.

Advocates

Inspectors spoke to two advocates from NIAMH who attend the ward every week and hold monthly meetings with patients. The advocates stated that they were welcomed on the ward by staff. They can attend the ward round on behalf of the patients if requested and they also attend the patient resettlement meetings. The advocates stated that they felt the patients received a good level of care on the ward.

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

Questionnaires issued to	Number issued	Number returned
Ward Staff	25	10
Other Ward Professionals	5	0
Relatives/carers	9	0

Ward Staff

Ten questionnaires were returned by ward staff in advance of the inspection. Information contained within the staff questionnaires demonstrated that nine out of the ten staff were aware of the Deprivation of Liberty Safeguards (DOLS) – interim guidance. Two out of the ten staff had received training in the areas of Human Rights and capacity to consent. All staff stated they were aware of restrictive practices on the ward. Examples of restrictive practices as reported by staff included “locked ward” “management of patient’s finances” and “set meal times” Two of the ten staff members had received

training in restrictive practices. Recommendations have been made in relation to this.

Two staff members who returned their questionnaires stated they had received training on meeting the needs of patients who need support with communication and nine staff members stated they were aware of alternative methods of communication. Six staff members stated that these were used in the care setting and nine members of staff confirmed that the ward has processes in place to meet patients' individual communication needs on the ward. Ten staff members reported that patients had access to therapeutic and recreational activities and nine staff members stated that these programmes meet the patient's needs.

Other Ward Professionals

No questionnaires were returned from other ward professionals.

Relatives/carers

No questionnaires were returned from relatives/carers professionals.

7.0 Additional matters examined/additional concerns noted

Complaints

Inspectors reviewed complaints received by the ward between 1 April 2013 and 31 March 2014. Two complaints were recorded over this period of time one in relation to patient's finances by a relative and one in relation to food and nutrition by a patient. Both complaints had been resolved to the satisfaction of the relative and patient. Inspectors noted that the ward had followed the Trusts policy and procedure in relation to the recorded complaints.

Inspector completed a direct observation of the ward and observed the female area of the ward and noted that the area was very small and confined with only the patients bedrooms and one day room. Patients had to go through a locked door to the dining room and other areas of the ward. The day room was very small and was not able to facilitate the patients on the ward and a staff member.

Since the ward amalgamated with other wards in the hospital staff on the ward stated that they were unsure of the overall purpose and function of the ward. Senior management stated that the wards overall function is rehabilitation and resettlement for patients with ensuring mental illness.

8.0 RQIA Compliance Scale Guidance

Guidance - Compliance statements		
Compliance statement	**Definition**	**Resulting Action in Inspection Report**
0 - Not applicable	Compliance with this criterion does not apply to this ward.	A reason must be clearly stated in the assessment contained within the inspection report
1 - Unlikely to become compliant	Compliance will not be demonstrated by the date of the inspection.	A reason must be clearly stated in the assessment contained within the inspection report
2 - Not compliant	Compliance could not be demonstrated by the date of the inspection.	In most situations this will result in a requirement or recommendation being made within the inspection report
3 - Moving towards compliance	Compliance could not be demonstrated by the date of the inspection. However, the service could demonstrate a convincing plan for full compliance by the end of the inspection year.	In most situations this will result in a recommendation being made within the inspection report
4 - Substantially Compliant	Arrangements for compliance were demonstrated during the inspection. However, appropriate systems for regular monitoring, review and revision are not yet in place.	In most situations this will result in a recommendation, or in some circumstances a recommendation, being made within the Inspection Report
5 - Compliant	Arrangements for compliance were demonstrated during the inspection. There are appropriate systems in place for regular monitoring, review and any necessary revisions to be undertaken.	In most situations this will result in an area of good practice being identified and being made within the inspection report.

Follow-up on recommendations made following the announced inspection on 25 & 26 June 2012

No.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	It is recommended that the advocate is more actively involved in Carrick 4 and attends regular patients meetings.	Inspectors met with two advocates from NIAMH who attend the ward each week to speak with patients individually and once a month they facilitate a group meeting with patients. Minutes are recorded and any issues raised are discussed with the ward manager.	Fully Met
2	It is recommended that all case files are regularly audited.	On the days of the inspection the inspectors reviewed care documentation and noted that files had been regularly audited.	Fully met
3	The complaints policy is on a standing agenda at patient's meetings.	Information on complaints is available throughout the ward and in the patient's individual handbook. Advocates hold regular one to one sessions with patients at their request and patient group meetings where patients can raise complaints. Each morning staff hold a de-briefing team meeting and records evidence that complaints are discussed every day at this meeting.	Fully met
4	It is recommended that vulnerable adult's policies are included in corporate induction programme.	Inspectors reviewed the wards induction programme and there was evidence that vulnerable adult training was included as part of this programme	Fully met
5	All staff should have the opportunity to participate in regular formal supervision sessions. These should be recorded and maintained in staff files.	Inspectors reviewed staff supervision records. There was evidence that all staff members had received formal supervision.	Fully met
6	It is recommended that staff meetings are scheduled regularly	Staff de-briefing meetings are held each morning and minutes recorded. Inspectors noted issues regarding	Fully met

	and minutes recorded.	complaints/vulnerable adults/physical interventions and progress of each patient are discussed each day.	
7	It is recommended that formal staff meetings are held quarterly, and that minutes are recorded and distributed to all staff working on ward.	Inspectors reviewed minutes of daily staff meetings held on the ward and all staff could access these minutes	Fully met
8	It is recommended that the ward manager works with patients advocates, carers and staff to develop a code of behaviour.	Codes of behaviour for staff was displayed on the notice boards and all staff working within the ward work in accordance with their own professionals codes of practice.	Fully met
9	It is recommended that the ward manager conducts audits of safeguarding activity.	This inspection was unannounced and the ward manager was off duty therefore inspectors were unable to access records of safeguarding audits This recommendation will be assessed during the next inspection.	Not assessed
10	It is recommended that patients are encouraged to talk to the advocate on a regular basis and that the advocate attends the patient meetings	Inspectors met with two advocates from NIAMH who attend the ward each week to speak with patients individually and once a week they facilitate a group meeting with patients. Minutes are recorded and any issues raised are discussed with the ward manager.	Fully met
11	It is recommended that ward staff conduct an audit of patient and carer views on inclusivity or transparency within the ward. An action plan should be developed to maximise patient and carer involvement.	Inspectors reviewed minutes of advocate meetings and there was evidence that patient's views are documented and discussed with the ward manager. There was evidence in the four sets of care documentation that carers and patients views were taken into consideration with regard to their overall care and treatment	Fully met

12	It is recommended that staff review the use of standardised deprivation of liberty care plans and record exactly what the restrictions exactly and why they are required. Reference should be made to specific Human Rights and reciprocity.	Inspectors reviewed four sets of care documentation. There was evidence that core care plans were still being used in relation to deprivation of liberty. These care plans did not detail the rationale for the level of restriction in terms of necessity and proportionality. This recommendation will be restated for a second time.	Not met
13	It is recommended that the advocate is encouraged to assist patients to write letters if the Freedom of information policy is invoked.	Inspectors met with two advocates from NIAMH who attend the ward each week to speak with patients individually and once a week they facilitate a group meeting with patients. They informed the inspectors that they assist patients in various ways such as raising complaints/concerns; assisting patients to complete reports so they can be reviewed at the mental health review tribunal and also accessing records. Inspectors spoke to one patient who confirmed that they were receiving assistance from one of the advocates on the ward with accessing their medical records.	Fully met
14	It is recommended that ward staff maintain a record of patients clothing and property to include any items whilst purchased whilst on ward.	Records of patients clothing and property is included in the integrated care pathway documentation which in held in each patients file	Fully met
15	Staff training in UNOCINI and 'recognising and responding to child abuse is not completed in line with Trust policy.	The clinical nurse support confirmed that the policy within the Northern Health and Social Care Trust is that all band 6 and 7's should have UNOCINI training. This was confirmed in the training records reviewed by the inspectors.	Fully met

16	It is recommended that dental hygiene is included as a topic of health promotion activity or in the community living skills group.	All patients have a physical health check when admitted to the ward. Records reviewed by the inspectors detailed that dental appointments had been arranged for patients. There is a dentist on the hospital site and when patient's need treatment they can be referred to this service. Health promotion forms part of the wards activity schedule	Fully met
17	It is recommended that patients are positively and repeatedly offered and encouraged to participate in smoke cessation activity. This should include the use of Nicotine replacement therapy.	There was evidence in the care documentation that patients were referred onto the smoking cessation practitioner. The clinical nurse support informed inspectors that a new programme is being rolled out for staff which gives them information on all the support mechanisms that are available for patients to assist them in giving up smoking.	Fully met
18	It is recommended that patients are proactively encouraged to maintain person hygiene, attend to laundry needs, purchase new clothing and wear clean clothing.	Inspectors reviewed four sets of care documentation. There was evidence that patients were encouraged to maintain person hygiene, attend to laundry needs, purchase new clothing and wear clean clothing. Occupational therapy assessments have been completed for patients with emphasis on promoting their independent living skills.	Fully met
19	It is recommended that the cost and location of the payphone is reviewed and appropriate action taken to address staff and patient concerns.	A pay phone was available for patients to make a phone call in private. The second payphone that was situated in the patient's communal area on the ward has been removed and a new line has been installed into a private room. The ward is waiting on connection of this line.	Fully met

Appendix 1

Follow-up on recommendations made following the patient experience interview inspection on 6 December 2013

No.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	It is recommended that the ward manager ensures there is a copy of the physical intervention form available in the patient's notes.	The ward staff continue to send the physical intervention forms to the administration team and when signed off by senior management these forms are then returned to the ward. During this time a copy is not retained in the patients care documentation. This recommendation will be restated for a second time**.**	Not met
2	It is recommended the ward manager ensures information in relation to advocacy service is in a format that meets the patient's communication needs.	Information leaflets are displayed on the ward in relation to advocacy. The advocates from NIAMH attend the ward each week and hold weekly meetings with the patients. New patients are informed on admission and are offered the opportunity to meet with them.	Fully met
3	It is recommended the ward manager reviews the location of the ward pay phone	The pay phone has been moved in the female part of the ward so that patients can make calls in private. In the male part of the ward, the line has been moved and staff are waiting on the line to be connected. This is also in a private room.	Fully met
4	It is recommended the ward manager reviews the frequency of the cleaning and disposal of smoking debris at the entrance to the ward.	On the day of the inspection this area was noted to be clean.	Fully met

Appendix 1

Follow-up on recommendations made following the patient experience interview inspection on 20 May 2014

No.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	It is recommended the ward manager ensures the current level of staff and patient interactions is reviewed to ensure a therapeutic environment is available to patients	The ward currently has one fulltime occupational therapist, one part time occupational therapist and an occupational therapy assistant on the ward. In the four sets of care documentation reviewed by the inspectors there was evidence that patients had had an occupational therapy assessment completed and a timetable devised from this assessment. Inspectors observed good interactions between staff and patients during the inspection.	Fully met
2	It is recommended the ward manager ensures where patients have initially refused to sign care plans is revisited with the patients and that is recorded.	There was evidence in the four sets of care documentation that patients care plans were reviewed regularly. Outcomes form the ward rounds were discussed with the patient by a nurse or doctor on the ward and the care plan was updated and signed. If patients' refused to sign this was documented in the care plan.	Fully met
3	It is recommended the ward manager reviews the method for reviewing patients care plans is reviewed and the date of review is recorded in the care plan documentation.	In the four sets of care documentation reviewed by the inspectors there was evidence that the care plans were reviewed and the date of review recorded.	Fully met

Appendix 1

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

No.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	It is recommended that the ward manager ensure that all staff attend up to date training in the management of patients' monies and valuables.	Inspectors were advised that training in the management of patients' monies and valuables is not currently available to staff working on the ward. Inspectors were advised that staff will liaise with colleagues in the finance department within the Trust in relation to making this training available. This recommendation will be restated for a second time.	Not met
2	It is recommended that the ward manager ensures that a record of all staff who obtain the key to the safe where patients' money is stored is maintained including the reason for access.	The key of the safe is retained by the nurse in charge of the ward. A record is maintained of staff who obtain the key and the reason for access.	Fully met
3	It is recommended that the ward manager ensures that individual patient statements are received from the cash office in order to verify that transactions are correct	Inspectors were informed that this process has not been implemented This recommendation will be restated for a second time.	Not met
4	It is recommended that the ward manager ensures that accurate and appropriate records and receipts are maintained for monies received by patients form the cash office through ward staff.	Inspectors noted that staff record the amount of money each patient receives and this was signed by two members of staff. Receipts were retained for each item purchased. This was countersigned by two members of staff.	Fully met
5	It is recommended that the ward manager ensures that a record of individual purchases made by patients is maintained and verified by reconciliation with cash ledger withdrawals	Inspectors noted there was a record of patient's individual purchases. Receipts were sent to the cash office to verify the patients balance. There was a record of the date, how much money was spent any remarks, and the balance was also countersigned by two members of staff.	Fully met
6	It is recommended that the ward manager ensures that a system to verify clothes purchased for patients are checked by ward staff against the	Inspectors noted receipts were checked against the patients balance and signed by two members of staff to verify that the records were correct in relation to the	Fully met

	receipt and confirmed as received by the patient.	purchases made.	
7	It is recommended that the Trust reviews the systems in place in relation to the number of different people authorised to withdraw monies from patients' cash office accounts.	Inspectors noted that this procedure has been reviewed. Nursing staff are now the only members of staff two are authorised to withdraw money from patient's cash office accounts. A record of this withdrawal is signed by to two members of staff.	Fully met
8	It is recommended that the ward manager ensures that withdrawals made from patients' accounts by occupational therapists are appropriately requested, receipted, verified and reconciled.	Inspectors were informed this system was been reviewed and the occupational therapist no longer withdrew money from patient's accounts.	Fully met
9	It is recommended that the ward manager ensures that regular weekly checks of patients' money held against the cash ledger are undertaken and appropriately recorded.	There were no evidence on the days of the inspection which indicated that the ward manager was completing regular weekly checks of patients' money held against the cash ledger. This recommendation will be restated for a second time	Not met
10	It is recommended that the ward manager ensures that all staff are made aware of the decision making and agreements in place in relation to the management of individual patients' finances.	Inspectors noted in four of the 15 sets of care documentation reviewed that when there are concerns raised regarding patients ability to manage their own finances, capacity assessments had been completed.	Fully met

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

No.	SAI No	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	N/A	N/A	N/A	N/A

Quality Improvement Plan

Unannounced Inspection

Carrick 4, Holywell Hospital

27 & 28 October 2014

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

The specific actions set out in the Quality Improvement Plan were discussed with the nurse in charge, the resettlement social worker and the clinical nurse support on the day of the inspection visit.

It is the responsibility of the Trust to ensure that all requirements and recommendations contained within the Quality Improvement Plan are addressed within the specified timescales.

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
1	5.3.1 (c)	It is recommended that the ward manager conducts audits of safeguarding activity.	2	Immediate and ongoing	The ward manager will formally review ward safeguarding activity with the multi disciplinary team from January 2015 having added SVA as a rolling agenda item at the monthly business meetings. The ward manager is also involved with the hospital education facilitator and colleagues to develop an audit tool to review the effectiveness of safeguarding vulnerable adult training. This tool will be utilised following its expected completion in January 2015.
2	7.3.(c)	It is recommended that staff review the use of standardised deprivation of liberty care plans and record exactly what the restrictions exactly and why they are required. Reference should be made to specific Human Rights and reciprocity.	2	31 December 2014	All Deprivation of Liberty (DoLs)care plans have been reviewed and are now individualised and record any restriction of liberty or infringement of Human Rights primarily due to mental illness or hospitalisation. The plans clearly state the measures in place to minimise infringement of rights and provide as positive a plan of care as possible whilst in hospital.
3	5.3.1 (f)	It is recommended that the ward	2	Immediate	Keeping a copy of the physical intervention form

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
		manager ensures there is a copy of the physical intervention form available in the patient's notes.		and ongoing	was identified previously and was established as part of regular practice in Carrick 4. The ward manager has reiterated this practice of keeping a copy until the original is returned from governance through daily supervision sessions and through induction of new staff. The ward manager will monitor this practice formally in four weekly operational supervision to ensure it happens on every occasion.
4	4.3.(m)	It is recommended that the ward manager ensure that all staff attend up to date training in the management of patients' monies and valuables.	2	31 March 2015	The ward manager has liaised with the education and training facilitator and has identified the need for training in this area. The dates identified for training are 29 December 10 am - 12 noon, 30 December 10 am – 12 noon and a date will be arranged for the first week in January.
5	4.3 (b)	It is recommended that the ward manager ensures that individual patient statements are received from the cash offices in order to verify that transactions are correct.	2	Immediate and ongoing	Where patient's give consent, ward staff assist the patient to review their cash statements and ascertain that they are correct. If a patient refuses to supply receipts or comply with these checks, this will be recorded.

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
6	5.3.1 (f)	It is recommended that the ward manager ensures that regular weekly checks of patients' money held against the cash ledger are undertaken and appropriately recorded.	2	Immediate and ongoing	The ward manager has commenced weekly reviews of the cash ledger and patient's money, and records this process within the ledger
7	7.3 (c)	It is recommended that the ward manager ensures that all staff receive training in capacity to consent, human rights, restrictive practices and the Deprivation of Liberty Safeguards (DOLS) – Interim Guidance.	1	31 March 2015	Training will be developed by Wendy Moore Education/Training Facilitator Mental Health for delivery during January 2015.
8	7.3.(C)	It is recommended the ward manager ensures that all deprivation of liberty care plans are person centred and linked to patients comprehensive risk assessments. The ward manager should ensure these care plans are completed in accordance with the deprivation of liberty safeguards (DOLS) interim guidance and in accordance with the NHSCT local policy on deprivation of liberty	1	31 December 2014	Named nurses are reviewing each patient's DoLs care plans, ensuring they are individualised, person-centred and linking them to their respective comprehensive risk assessment. This is in accordance with the information available at ward level as above.

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
9	4.3 (n)	It is recommended the Trust review the current medical input on the ward to ensure all patients are offered the opportunity to attend their weekly MDT meetings	1	31 March 2015	Every inpatient in Carrick 4 has a Consultant Psychiatrist who attends a weekly multi-disciplinary meeting, patients have the opportunity to attend.
10	5.3.3.(a)	It is recommended that the ward manager ensures that information in relation on the detention process and the mental health review tribunal is included in the patients individual handbook	1	31 December 2014	The handbook has been updated to include this information. All patients who currently hold a handbook will be given this updated section to include in their hand book if they choose to do so by 24 December 2014.
11	5.3.1.(a)	It is recommended that the ward manager ensures that all comprehensive risk assessments are completed in accordance with the Promoting Quality Care- Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services	1	31 December 2014	The ward manager and MDT are reviewing each comprehensive risk assessment to ensure they meet the expected standards of the guidance. All assessments will be reviewed by 31 December 2014.
12	7.3 (a)	It is recommended that the ward manager ensure that that occupational therapist's annual leave arrangements are reviewed by their	1	31 December 2014	The occupational therapists are aware to inform the ward manager of leave arrangements, they are aware to ensure cover is maintained unless due to

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
		management to ensure adequate covered on the ward			unavoidable situations. At these times contingency plans will be made to continue an activity programme.
13	7.3 (a)	It is recommended that the ward manager develops a structured recreational activity schedule for evenings and weekends which will consider the individual needs and views of the patients.	1	31 December 2014	A timetable has been developed to inform the patients of the activities available or arranged seven days and evenings per week. This is on display in patient areas. In addition a weekly leisure/hobby evening has been introduced by O.T staff from December 2014, patients will be asked to identify new activities for these.
14	5.3.3 (a)	It is recommended that the ward manager ensures that all patients who have been detained under the Mental Health (Northern Ireland) Order 1986 have been given information on their rights in relation to the MHRT and the detention process	1	Immediate and ongoing	All patients have been informed of their rights under the mental health order, and they have received this verbally from named nurse, and they have received information leaflets and informed of their right to appeal. A new section has been added to the Integrated Care pathway to ensure receipt of same has being clearly documented.
15	6.3.1 (a)	It is recommended that the Trust review the communal space for female patients on the ward	1	31 March 2015	This space is currently being reviewed by MDT and plans are being discussed on how to make best usage of the space available in ward. Options

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
					have been identified and the best option for patients will be put forward for discussion and implementation by 31 January 2015.
16	4.3 (e)	It is recommended that ward manager ensures that all staff are aware of the overall purpose and function of Carrick 4 ward since it amalgamated with other wards on the hospital site.	1	Immediate and ongoing	The MDT have recently met and reviewed and updated the operational policy for the ward. The ward manager will share this with all disciplines, will discuss at the next staff meeting and daily through the daily supervision sheet to inform and get views of all staff. Comments will be taken back to the MDT. Final version will be approved by December 2014

NAME OF WARD MANAGER COMPLETING QIP	John Quinn
NAME OF CHIEF EXECUTIVE / IDENTIFIED RESPONSIBLE PERSON	Dr T Stevens

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

APPROVING QIP	

Inspector assessment of returned QIP				**Inspector**	**Date**
		Yes	**No**		
A.	Quality Improvement Plan response assessed by inspector as acceptable	x		Audrey McLellan	23/12/14
B.	Further information requested from provider				

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

Ward Self-Assessment	
Statement 1: Capacity & Consent • **Patients' capacity to consent to care and treatment is monitored and re-evaluated regularly throughout admission to hospital.** • **Patients are allowed adequate time and resources to optimise their understanding of the implications of their care and treatment.** • **Where a patient has been assessed as not having the capacity to make a decision there are robust arrangements in place in relation to decision making processes that are managed in accordance with DHSSPS guidance.** • **Patients' Article 8 rights to respect for private and family life & Article 14 right to be free from discrimination have been considered**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
Patients consent is sought and gained prior to any care or treatment being delivered. Where consent has not been obtained this is recorded in daily progress report. Changes in capacity are discussed at ward rounds by all professionals involved in their care. The care and treatment of each patient is and has been explained to them in a language which they can understand and without the use of jargon. Patients can avail of their allocated named nurse each day to discuss all aspects of their care and treatment; this is then recorded in daily progress notes. Patients are actively encouraged to participate in the drawing up of their own care plans when possible. Patient advocacy provided independently by NIAMH visit the ward on a weekly basis and are there to help patients with any concerns they want addressed in relation to all aspects of care and treatment and offer additional support to the patient if they feel they are not being heard. Care plans are in place to meet the requirements of this statement and are individualised to meet the specific needs of each patient. Care is reviewed and amendments made to same when required and patients are encouraged to be involved in this process. The ward has three separate visitor rooms to provide patients privacy with family and friends. Staff have had training in WRAP, Recovery Star, and HABIT. This is to enable them to support patients in their recovery. Article 8 and 14 are taken into consideration throughout the patients stay in hospital.	Substantially Compliant

Inspection Findings: FOR RQIA INSPECTORS USE Only	
The Northern Health and Social Care Trust Policy on Deprivation of Liberty Safeguards and Human Rights -13 August 2012 amended August 2014 was available for staff on the ward. This policy included the Deprivation of Liberty Safeguard (DOLS) Interim Guidance 2010. The policy on Consent for examination, treatment or care September 2010 was also available on the ward of staff. Inspectors spoke to four staff on the ward who demonstrated their knowledge and understanding of gaining consent to care and treatment and the process to follow if consent had not been gained. Eight out of the ten questionnaires returned indicated that staff had not received training in capacity to consent. A recommendation has been made in relation to this. In four of the15 sets of care documentation reviewed by inspectors there was evidence in the patients care plans, multi-disciplinary records and progress notes that patients were given the time to understand their care and treatment and that patients were continually assessed regarding the patient's ability to consent to care and treatment. It was documented that that staff had gained consent from patients on a daily basis, for example in order to assist patients with personal care and attend to therapeutic activities. It was good to note there was evidence in the care documentation that when concerns had been raised regarding patients ability to manage their finances a financial capacity assessment had been completed and care plans were updated detailing the plan in place to assist the patient in managing their finances whilst on the ward. The inspectors spoke to four patients on the ward who all stated that they had been consulted in all aspects of their care and treatment. All four patients stated that they have been involved in multi-disciplinary meetings and had felt that their views had been considered with regard to decisions about their future support needs and continual care and treatment. Consideration to Human Rights Article 8 respect for private and family life and Article 14 right to be free from discrimination was documented in the four sets of care documentation reviewed.	Substantially compliant

Ward Self-Assessment	
Statement 2: Individualised assessment and management of need and risk • **Patients and/or their representatives are involved in holistic needs assessment and in development of related individualised, person-centred care plans and risk management plans** • **Patients with communication needs have their communication needs assessed and there are appropriate arrangements in place to promote the patient's ability to meaningfully engage in the assessment of their needs, planning and agreeing care and treatment plans and in the review of their needs and services.** • **Assessment of need is a continuous process and plans are revised regularly with the involvement of the patient and/or their representative and in accordance with any changes to assessed needs.** • **Patients' Article 8 rights to respect for private and family life have been considered.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
. Patients when possible are involved in the process and each area has been explained to them including the rationale for responses. Care plans are reviewed on a regular basis either weekly, fortnightly or monthly, they are individualised and are person centred. All patients have an ICP in place and staff are currently in the process of completing multi- disciplinary care plans that are more detailed and explain to the patient in a language that they can understand their treatment and they are asked to sign these at the earliest opportunity. Where this is not possible the rights of the patient are fully advocated by their named nurse and other professionals. Patient involvement in care planning will be revisited at the earliest opportunity Family members are also included with consent from the patient in this process to ensure a holistic approach is maintained and demonstrated robustly. Carrick 4 has three visitor rooms which are off the ward to provide respect for private and family life.	Substantially Compliant

Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
Inspectors reviewed care records relating to four of the 15 patient's on the ward on the days of the inspection. Each record contained an integrated care pathway (ICP) which incorporated nursing, medical, occupational therapy, social work notes. An inpatient admission sheet, nursing and medical initial assessments, a risk screening tool, interim multi-disciplinary care plan, multi-disciplinary team reports and continuous communication sheets were also included within the ICP. All four sets of care documentation relating to four patients reviewed by the inspectors had a comprehensive need assessment completed which was a detailed multi-disciplinary assessment completed by nursing, medical, social work and occupational therapists. The assessment included information on family background, family composition, early years, medical history, education, employment, relationships, previous psychiatry history, hobbies, progress since admission, self-care functioning, summary, involvement in community life, spiritual needs, emotional wellbeing, patients expectations/moving resettlement, family /carers expectations resettlement, human rights consideration and summary of needs. It was good to note that assessments relating to all patients were individualised and person centred. Four patients who spoke to the inspectors indicated that they had been involved in their assessments, care plans and review meetings. The patients spoke positively about the staff on the ward and the care and treatment they have been receiving. Inspectors noted that the multidisciplinary Team (MDT) ward round was held each week. Each patient had the opportunity to attend and participate in a discussion regarding all aspects of their care and treatment plan at the weekly ward round. There was evidence in the four sets of care documentation that if patients did not attend the multi-disciplinary meeting, nursing staff or the doctor spoke to the patient individually and explained any proposed changes to their care and treatment plan, so agreement and consent could be gained. If patients refused to sign the care plan this was also documented in the care documentation. The management/action plans were updated after the ward round with the name of the professional who would undertake each area of work with timescales of when this would be completed recorded. However in one set of care documentation reviewed by the inspector there was no evidence that a multi-disciplinary meeting had been held for one patient since July 2014 due to the unavailability of the patient's consultant. This was also the case for another two patients on the ward on the days of the inspection. The three patients had been seen by the ward registrar. A recommendation has been made in relation to this In the four sets of care documentation reviewed by the inspectors there was evidence that both core care plans and individualised care plans were completed. The inspectors noted that the deprivation of liberty care	Moving towards Compliance

plans were core plans and were not individualised therefore the rationale was not proportionate to each individual patient. This will be discussed in more detail in statement 5. A recommendation has been made in relation to this The inspectors reviewed four sets of care documentation. Two out of the four sets of care documentation contained comprehensive risk assessments which were completed in accordance with the Promoting Quality Care- Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services May 2012. However one set of care documentation contained an assessment which was not signed by the patient and no record to indicate why the patient had not signed the document. The management plan had also been completed incorrectly. One set of care documentation had a risk screening tool completed which indicated that a comprehensive assessment needed to be completed however this was not in the care documentation. A recommendation has been made in relation to this Inspectors reviewed minutes of the daily team meeting convened each morning. It was good to note the following was discussed: vulnerable adult concerns, complaints, physical interventions, infection control, accidents and incidents, patients' progress and staffing levels. Any changes that had been agreed in relation to patients care and treatment was also discussed at this meeting to ensure continuity of care. Inspectors noted that patient's Article 8 rights to respect for private and family life was considered in the care documentation reviewed by the inspectors On the day of the inspection inspectors undertook a direct observation of the ward. Inspectors noted that interactions between the staff and patients were responsive, appropriate and respectful.	

Ward Self-Assessment	
Statement 3: Therapeutic & recreational activity • **Patients have the opportunity to be involved in agreeing to and participating in therapeutic and recreational activity programmes relevant to their identified needs. This includes access to off the ward activities.** • **Patients' Article 8 rights to respect for private and family life have been considered.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
Care plans reflect the individualised needs of each patient and all patients have a programme including occupational therapy in place to meet this requirement. Patients at staff /patient meetings chaired by the independent patient advocate (NIAMH) are encouraged to voice any ideas that will improve their quality of life. Patients are taken on recreational outings which reflect their personal interests such as the local cinema, leisure centre, fishing and pubs to promote this. Patients by their own suggestion have asked for more activities at weekends. To facilitate this nursing staff organise outings at the weekend to local places of interest to both as a group and on an individual basis. This is evidenced in daily progress reports. Opportunities for patients to spend time with families and friends is facilitated.	4 - Substantially Compliant
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
Carrick 4 ward currently has one full time occupational therapist, one part time occupational therapist and one occupational therapy assistant on the ward. Inspectors reviewed care documentation relating to four patients on the ward. There was evidence that occupational therapy assessments had been carried out for all four patients and individual timetables developed from these assessments. This included areas such as independent living skills, OT read, learn and live, accounts, shopping, gym, budgeting, road safety, cinema nights, cooking, household tasks and going to the Oasis. Patients were encouraged to participate in these programmes however if they did not wish to participate in the sessions the patient's non-attendance and the reason for this was also recorded in the care documentation. There was evidence in the four sets of care documentation that patient's progress with regard to their mental health condition and activities of daily living was recorded by the nursing staff and the occupational Therapist. On the days of the inspection inspectors were informed that two of the occupational therapists were on annual leave. Therefore this left one occupational therapist to cover the ward. It was noted by the inspectors that the level of activities provided by occupational therapy had been reduced. A recommendation has been made in relation to this.	Substantially compliant

Three of the four patients who spoke with inspectors stated they would like more activities arranged over the weekend and in the evenings. A recommendation has been made in relation to this. Ward based, hospital based or community based therapeutic and recreational programmes were offered to patients and in accordance with each patient's individual need and risk assessment. The multidisciplinary team assessed each patient's mental health at all stages. The occupational therapists on the ward completed the comprehensive needs assessments as part of the multi-disciplinary assessment for all patients on the ward. Inspectors assessed that the patient's Human Rights article eight, the right to respect for private and family life, had been considered with regard to the therapeutic and recreational activities.	

Ward Self-Assessment	
Statement 4: Information about rights • **Patients have been informed about their rights in a format suitable to their individual needs and access to the communication method of his/her choice. This includes the right to refuse care and treatment, information in relation to detention processes, information about the Mental Health Review Tribunal, referral to the Mental Health Review Tribunal, making a complaint, and access to independent advocacy services.** • **Patients' Article 5 rights to liberty and security of person, Article 8 rights to respect for private and family life and Article 14 right to be free from discrimination have been considered.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
All patients are fully informed of their individual rights in relation to the detention process, MHRT, complaints and advocacy services. This is demonstrated and evidenced in progress reports and completion and signing of detention information forms. Patients are given this information in language that is suitable to their individual needs. The independent patient advocacy service attends ward on a weekly basis to meet with patients and discuss any issues they may have. The patient advocate now chairs the staff /patient meetings. The patients can also access the citizen advice bureau who visits the ward and meets patients on a referral basis. Information on complaints and how to make them is displayed on ward notice boards and a copy is included in the welcome pack. A record of complaints/comments /compliments is now being kept to demonstrate this and evidence how same are dealt with.	Moving towards compliance
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
There was evidence throughout the care documentation reviewed that the multidisciplinary team had considered, patients human rights in relation to article 5, 8, and 14. Thirteen of the fifteen patients on the ward on the days of the inspection were subject to detention under the Mental Health (Northern Ireland) Order 1986. Three of the four sets of care documentation reviewed by inspectors belonged to patients who were subject to detention under the Mental Health (Northern Ireland) Order 1986. Two of these patients had care plans in place which detailed that they had been given information on their rights in relation to Mental Health Review Tribunal (MHRT) and the detention process. These patients had also been given information on the advocacy service. However one patient who was detained under the Mental	Moving towards compliance

Health (Northern Ireland) Order 1986 had no care plan in place to demonstrate that they had been given information on their rights in relation to MHRT and the detention process. A recommendation has been made in relation to this. Eight out of the ten questionnaires returned by staff in advance of the inspection indicated that staff had not received training in human rights. A recommendation has been made in relation to this. The Inspectors met with four patients on the ward. All four patients informed the inspectors that they had been involved in their care and treatment and had felt that the doctors and nurses had listened to them when discussing their care and treatment. All four patients were aware of the advocacy service and knew who their named nurses were. They also knew who to speak to if they needed to make a complaint. Patients were aware that they could meet with the nursing staff and the consultant to discuss their rights in relation to accepting and refusing care and treatment. There was evidence in the four sets of care documentation reviewed by the inspectors that patients were aware of their rights in relation to accepting and refusing care and treatment. Information in relation to the complaints procedure and the advocacy service was available on the ward this information was also recorded in the patients' individual handbook. It was good to note that two advocates from NIAMH had attended the ward on a weekly basis and had convened regular monthly meetings with the patients. Each patient received an individual ward information handbook on admission to the ward. This was a comprehensive booklet which contained information on 'my care team', identifying staff, meal times, visiting times, clothing and belongings, medication, violence and aggression policy, drugs and alcohol, confidentiality, disability/special needs, advocacy, carers, Regulation and Quality Improvement Authority, compliments and complaints, ward facilitates, hospital facilities, services provided by rehab MDT team, daily timetable, plans for the future, support plan, useful telephone numbers, dates to remember and feedback forms. However there was no information in this booklet that gave patients information in relation on the detention process and the mental health review tribunal. A recommendation has been made in relation to this The four staff who met with the inspectors were aware of the role and function of the advocacy service and how to refer patients to this service.	

Ward Self-Assessment	
Statement 5: Restriction and Deprivation of Liberty • **Patients do not experience "blanket" restrictions or deprivation of liberty.** • **Any use of restrictive practice is individually assessed with a clearly recorded rationale for the use of and level of restriction.** • **Any restrictive practice is used as a last resort, proportionate to the level of assessed risk and is the least restrictive measure required to keep patients and/or others safe.** • **Any use of restrictive practice and the need for and appropriateness of the restriction is regularly reviewed.** • **Patients' Article 3 rights to be free from torture, inhuman or degrading treatment or punishment, Article 5 rights to liberty and security of person, Article 8 rights to respect for private & family life and Article 14 right to be free from discrimination have been considered.**	**COMPLIANCE LEVEL**
Patients have deprivation of liberty care plans in place to meet their individual needs, and they have been explained to the patients in language which they understand. Their needs are assessed and reviewed on an individual basis and this is reflected in the care plans also. It is proportionate to their own individual assessed risk and is of the least restrictive measure as possible. All above articles have been considered to ensure this.	Substantially Compliant
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
The Northern Health and Social Care Trust Policy on Deprivation of Liberty Safeguards and Human Rights -13 August 2012 amended August 2014 was available for staff on the ward. This policy included in the Deprivation of Liberty Safeguard (DOLS) Interim Guidance 2010. Each patient on Carrick 4 ward had an individual activity plan set up by the occupational therapists on the ward. The main objectives of the timetables were to increase patient's skills in all areas of daily living and this included activities being undertaking outside the ward environment. The ward is a locked environment however patients were able to access ward, hospital and community based activities when this had been risk assessed and agreed by the MDT. Patients' rights were continually discussed at each ward round. Information was available on the ward on the	Substantially complaint

patient advocacy service, MHRT and the complaints procedure. Inspectors reviewed four sets of patients care plans in relation to deprivation of liberty. Inspectors noted that these care plans were not individualised and did not detail the rationale for the restriction of patients requiring a secure ward, restriction on patient's money, fluid restrictions, physical interventions and restriction in relation to activities they take part in. In one set of care documentation it stated that "due to various risks X needs a locked door". There was no clarification of what the risks were. One care plan stated that the locked door on the ward infringed on the patients right to family life but did not detail that it was infringing on the patient's right to liberty. The occupational therapist had completed an assessment on this patient and had stated that the patient had limited ability with regard to road safety and there would be risks with them accessing the road and there were risks of harm to self and others. However this was not detailed in the care plan as the reasons why the patient's liberty was restricted and therefore the rationale could be viewed as not proportionate to the restriction. A recommendation has been made in relation to this There was also no acknowledgment of the patient's human right article 5 throughout the care plans. It was good to note that eight out of the ten staff members indicated that they were aware of the Deprivation of Liberty Interim Guidance 2010. However eight out of the ten members of staff indicated they had not received training in restrictive practices. A recommendation has been made in relation to this.	

Ward Self-Assessment	
Statement 6: Discharge planning • **Patients and/or their representatives are involved in discharge planning at the earliest opportunity.** • **Patients are discharged home with appropriate support or to an appropriate community setting within seven days of the patient being assessed as medically fit for discharge.** • **Delayed discharges are reported to the Health and Social Care Board.** • **Patients' Article 8 rights to respect for private and family life have been considered.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
Patients and/or their representative are fully involved in discharge process from the patients' admission to the ward. The MDT is constantly seeking appropriate facilities to meet the individual needs of each patient. ICPs and CMAs are completed this guides us to provide the patient with the right choices and locations of accommodation to meet their needs. Patients on discharge have a full package of care that has been tailored to meet their needs to ensure their success in discharge and promote on-going recovery.	Substantially Compliant
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
It was good to note that resettlement meetings are held every month for patients on the patient transfer list (PTL). Inspectors were advised by the resettlement officer that it is planned that four patients will be moving out of the hospital by January 2015. Multi-disciplinary team resettlement meetings are held with relevant outside organisations and the patients advocate. The agenda for the meetings include discussions around the patient's assessment in relation to readiness for resettlement, progress on community schemes development and financial mapping and resettlement costs to date. Inspectors spoke to the social worker on the ward who is involved in resettling patients into the community who are currently on the PTL list. The social worker discussed their role in detail and advised that all professionals are working closely together to ensure patients are placed in suitable accommodation and are provided with the appropriate level of support to meet their individual needs. Each patient had a comprehensive multi-disciplinary assessment completed and a comprehensive risk management plan along with a care plan so that patients are provided with continuity in their care. Once a placement has been sourced the social worker meets with the patients to discuss the placement and to gain their views and the views of their representative if appropriate. If patients are in agreement then multi-disciplinary discharge planning meetings are held with the patients and their	Compliant

representatives to discuss and agree future developments and arrangements. Inspectors spoke to four patients who discussed the options available to them with regard to their discharge. One patient was currently on a phased transition to a new facility and advised that they were looking forward to the move and stated that their new home was “lovely”. Another patient advised that professionals were looking at a supported living home for them however they stated that they felt they would like to return to their own home. The patient advised they were involved in the discharge arrangements and felt staff listened to them. They also had the support of the advocates on the ward from NIAMH The nurse in charge stated that there were ten patients on the Carrick 4 who were assessed as delayed in their discharge from hospital and the reason for this was that there were not enough suitable placements in the community for these patients. It was good to note that there was also a social worker on the ward who is sourcing placements in the community for these patients who are not currently on the PTL. Inspectors noted that the patient’s article 8 rights to respect for private and family life was considered as part of discharge planning. This was evidenced through the involvement of the patient and their relative/carer in the care documentation.	

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