The Regulation and Quality Improvement Authority

RQIA

Mental Health and Learning Disability

Unannounced Inspection

Inver 1, Holywell Hospital

Northern Health and Social Care Trust

11 and 12 March 2015

national preventive mechanism

informing and improving health and social care

www.rqia.org.uk

Contents

1.0 General Information

Ward Name	Inver 1, Holywell Hospital
Trust	Northern Health and Social Care Trust
Hospital Address	Holywell Hospital 60 Steeple Road Antrim BT41 2RJ
Ward Telephone number	028 9446 5211
Ward Manager	Yvonne McElhinney
Email address	yvonne.mcelhinney@northerntrust.hscni.net
Person in charge on day of inspection	Yvonne McElhinney
Category of Care	Acute mental health service, Female Psychiatric Intensive Care
Date of last inspection and inspection type	12 August 2014, patient experience interview inspection
Name of inspector(s)	Alan Guthrie Dr Brian Fleming

2.0 Ward profile

Inver 1 is a five bedded female ward in the main building on the Holywell hospital site. The purpose of the ward is to provide assessment and treatment to patients who require acute inpatient psychiatric assessment and treatment in an intensive care environment. The main entrance doors to the ward are locked. Access to and from the ward can be gained via key fob.

The multidisciplinary team consists of a team of nursing staff and health care assistants, a consultant psychiatrist, a doctor and an occupational therapist. On the days of the inspection there were five patients admitted to the ward in accordance to the Mental Health (Northern Ireland) Order 1986.

3.0 Introduction

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

3.1 Purpose and Aim of the Inspection

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

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

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

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

3.2 Methodology

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

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

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

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

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

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

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

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

4.0 Review of action plans/progress

An unannounced inspection of Inver 1, Holywell Hospital was undertaken on 11 and 12 March 2015.

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

The recommendations made following the last announced inspection on 9 September 2013 were evaluated. The inspector was pleased to note that 17 recommendations had been fully met and compliance had been achieved in the following areas:

- the recording of minutes of patients meetings had been reviewed and a copy of the previous minutes was available for patient use;
- the provision of ward based activities had been reviewed and patients who met with inspectors demonstrated awareness of the activities available;
- the ward manager had introduced a system to audit patient records;
- a system had been introduced to ensure that bank staff working on the ward had the appropriate training skills and knowledge;
- the ward manager had developed a procedure to ensure that compliments were recorded;
- a procedure to document locally resolved complaints was available;
- the implementation of monthly file audits helped to ensure that all care documentation was completed in accordance to professional guidance documents including NMC Record keeping guidance;
- patient progress records and patient signatures evidenced that risk assessments and care plans had been discussed with the patient;
- all substances on the ward were being stored in accordance with Control of substances hazardous to health (COSHH) regulations;
- the ward's cook continued to liaise with patients in Inver 1 to review the quality, quantity and choice of food available;
- a patient's discharge from the ward was being managed with respect and consideration to the patient's human rights, dignity and choice.

However, despite assurances from the Trust, 13 recommendations had not been fully implemented. Three recommendations had been partially met and ten recommendations had not been met.

10 recommendations will require to be restated for a second time and three recommendations will be restated for a third time, in the Quality Improvement Plan (QIP) accompanying this report.

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

The recommendations made following the finance inspection on 2 January 2014 were evaluated. The inspector was pleased to note that all six

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

- the ward manager had ensured that a record of all staff who obtain the key to the cupboard where patients' money was being maintained;
- purchases made by staff on behalf of patients were being appropriately recorded;
- records of purchases made, and change returned to patients following outings were being maintained;
- a record of purchases made on behalf of patients was being appropriately recorded and receipted in the ward's cash ledger;
- regular checks of patients' money held against the cash ledger were being completed;
- statements from the cash office were provided to patients upon discharge.

5.0 Inspection Summary

Since the last inspection a number of changes to care practices had been introduced. Patient/staff meetings were held on a regular basis and patients were being informed of their rights. Patients could also access the ward's advocacy service and the advocate visited the ward once every two weeks and as required. The ward's activity programme had been reviewed and patients reported positively on the occupational therapy programme. The ward manager had introduced file audits and a system to ensure clear oversight of staff training requirements and supervision timetables.

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.

Care documentation reviewed by inspectors evidenced that upon admission to the ward each patient was assessed using the Trust's integrated care pathway (ICP). A joint medical and nursing assessment was completed with each patient. This included a risk assessment and a mental state examination. The mental state examination incorporated an assessment of the patient's insight, motivation, cognition and perception and established the patient's capacity to consent to care and treatment. Patients' capacity to consent was continually monitored and reviewed by the multi-disciplinary team (MDT).

Inspectors reviewed the ward's protocols and procedures for the management of a patient who lacked capacity to consent to their care and treatment. Staff who met with inspectors demonstrated appropriate knowledge and understanding of how to manage and support a patient in these circumstances. Patients were also supported by the ward's advocate who facilitated an advocacy clinic on the ward every other Monday.

Patients had the opportunity to express their views to the advocate and through 1 to 1 contact with their named nurse and by attending the weekly

MDT care planning meeting. Patients who met with the inspectors reported they had found staff easy to talk to and helpful. Inspectors noted that patients were allowed time and given support to understand the implications of their care and treatment. This was evidenced in continuous MDT care records and by the feedback given to inspectors by patients who met with them. Patients reported no concerns regarding their ability to meet with nursing and medical staff.

Inspectors reviewed five sets of patient care records. Nursing and MDT care plans were reviewed and updated on a regular basis. Inspectors evidenced that nursing and MDT care plans had not been completed in accordance to Trust standards. One care plan did not record a rationale as to why the patient could only access cigarettes and soft drinks as certain times every hour. Care plans did not reflect the ward's use of internal locked doors with regard to necessity and the assessed needs of each patient. Recommendations have been made.

Patients who met with inspectors reported that the ward's therapeutic programme was provided on a daily basis and included activities outside the ward. Copies of the ward's therapeutic and recreational activity plans were available on a notice board in the patients' day area. Each patient had an individual activity timetable and patient participation in activities was recorded in their progress notes. Patients spoke positively about the ward's activity programme reporting that there were a range of activities provided by the ward's occupational therapist (OT).

Inspectors met with the OT and reviewed the ward's OT room. The ward's OT room was large, bright and airy. The room was well equipped although it had no sink. A recommendation has been made. The OT reflected positively on the MDT team and the support provided to patients. The OT reported that they felt their role was integrated within the ward and that therapeutic activity was effectively promoted and supported by ward staff. Alongside the ward's OT services other psychotherapeutic activities were also available. These included anxiety management, relaxation groups and wellness and recovery action planning (WRAP). Inspectors were informed that patients could not access psychology services during their admission. Recommendations regarding patient access to daily therapeutic activity and the provision of a range of therapeutic interventions have been restated.

The ward's information leaflet provided patients with details regarding the advocacy service, the complaints procedure, patients' rights and the Mental Health (Northern Ireland) Order1986. It was good to note that there were leaflets explaining the mental health review tribunal and the advocacy service. Inspectors found that the information available on the ward's notice boards was comprehensive. Patients who spoke with inspectors reported no concerns regarding their ability to speak with staff or to gain information as required. It was positive to note that the ward's cook attended the ward weekly to speak with patients about menu and food preferences.

Each of the five patients receiving care and treatment on the ward had been compulsorily admitted in accordance to the Mental Health (Northern Ireland)

Order 1986. To ensure patient safety and wellbeing the implementation of a number of restrictive practices was necessary. The ward's prohibited items list was reviewed and noted to be appropriate to help ensure the ward's environment remained safe.

Patient care plans reflected on the ward's locked environment although, as previously discussed, there was no rationale noted in relation to the need for internally locked doors. Care plans did not evidence a rationale regarding the removal of a number of patients' personal items including mobile phones, makeup and CD/MP3 players. Whilst recognising the removal of personal items may be necessary, the implementation of this restriction should be based on each patient's assessed needs. This was not reflected in the patient care plans reviewed by inspectors. Recommendations regarding the ward's internal locked doors and patients' property have already been made. A recommendation in relation to patient access to personal locked storage has been restated.

Inspectors reviewed the ward's processes for recording and reporting the use of physical intervention. Inspectors evidenced staff using appropriate de-escalation skills and records of the use of restraint and seclusion reflected a least restrictive practice ethos. Staff training and supervision records evidenced that all staff continued to receive support and up to date physical intervention training (MAPA training). It was good to note that 14 of the ward's 18 nursing staff had recently completed human rights awareness training.

Inspectors noted evidence that discharge planning for patients commenced upon their admission to the ward. The ward's patient information leaflet provided information to patients and their relative/carer regarding discharge planning. Discharge planning was also evident in the multi-disciplinary (MDT) care plan. The plan contained dates for care plan evaluation and the weekly MDT care plan review records continually referenced discharge planning. Four of the five patient discharge plans reviewed by inspectors were noted to be appropriate to the patient's needs. However, one plan did not provide a clear strategic management plan in relation to the patient's discharge from the ward. A recommendation has been made.

Discharge planning meetings were attended by the patient and their relative/carer. The aim of the meeting is to agree the arrangements for discharge with the patient and their family/carer. Arrangements for the continuation of outpatient treatment and provision of any services or social support including housing were also discussed.

Details of the above findings are included in Appendix 2.

On this occasion Inver 1has achieved an overall compliance level of substantially complaint in relation to the Human Rights inspection theme of "Autonomy".

6.0 Consultation processes

During the course of the inspection, the inspector was able to meet with:

Patients	5
Ward Staff	7
Relatives	0
Other Ward Professionals	1
Advocates	0

Patients

Patients who met with inspectors were complimentary regarding the care and treatment they had received on the ward. Patients were also positive about their relationships with staff and their ability to access staff support when required.

Patients reported no concerns regarding their ability to access activities and all of the patients informed inspectors that they felt safe on the ward. Patients relayed that the ward had a lot of rules and staff looked after some of their personal items. Patient comments included:

"The ward's unsettled at times…but mostly settled";

"It's terrible…I can't get fizzy drinks after 10 o'clock….staff ignore me…staff speak to me in private";

"It's good…it's strict";

"Treated fairly…I have had no problems…very friendly people";

"My things are locked in a room on the other side of the ward. I can get them when I want".

Relatives/Carers

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

Ward Staff

Inspectors met with seven members of the ward's multi-disciplinary team (MDT). Nursing staff reported that they found the ward's environment challenging. Nursing staff reflected that the ward's design and the limited space available impacted on ward routine and patient comfort. Nurses reported no concerns regarding their ability to access supervision and training.

The ward's occupational therapist (OT) reflected that the ward was focused on supporting patients in their recovery. The OT reported that this was a shared ethos within the ward and there was good support within the multi-disciplinary team. The OT also highlighted that there was good liaison between ward staff.

Staff comments included:

"The MDT listens to nursing opinion";

"My colleagues are approachable and responsive";

"Supportive management team";

"I enjoy working on the ward";

"I feel the ward is well managed";

"The buildings not great";

"…patients have limited space to store personal things";

"It can be difficult to observe patients from the main office".

Other Ward Professionals

Inspectors met with the Trust's mental health education and training lead nurse. The nurse advised inspectors that the ward's staff mandatory training programme was ongoing and update training deficits were being addressed. The nurse also advised that the bank staff managers ensured that bank staff working on the ward had appropriate skills and training.

Advocates

The ward's advocate was unable to meet with inspectors during the inspection.

Questionnaires

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

Questionnaires issued to	Number issued	Number returned
Ward Staff	15	9
Other Ward Professionals	5	0
Relatives/carers	7	0

Ward Staff

Nine questionnaires were returned by nursing staff. Each member of staff reported awareness of the restrictive practices used within the ward and all staff indicted that they had received training in relation to restrictive practice. Staff listed restrictive practices to include: the use of locked doors, observations, physical interventions, restrictions on certain items, controlled access to the ward and use of the Mental Health (Northern Ireland) Order 1986.

Staff reported that they felt the ward provided relevant information to patients in a format appropriate to each patient's individual needs. Staff also recorded that each patient's individual therapeutic and activity needs were considered and appropriately addressed. No additional comments were received.

Other Ward Professionals

No other ward professionals returned questionnaires.

Relatives/carers

No questionnaires were returned by relatives.

7.0 Additional matters examined/additional concerns noted

Complaints

Inspectors reviewed complaints received by the ward between the 1 April 2013 and the 31 March 2014. Four complaints had been received during this period. Two complaints were received from service users and two complaints had been received from relatives. All of the complaints related to care practice. Complaints had been resolved to the full satisfaction of the complainant.

Inspectors found the ward's complaint procedure to be in accordance with the Trust's policy and procedure. Inspectors noted that information relating to the complaints procedure was available to patients and their carer/relatives.

8.0 RQIA Compliance Scale Guidance

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

Appendix 1 – Follow up on Previous Recommendations

The details of follow up on previously made recommendations contained within this report are an electronic copy. If you require a hard copy of this information please contact the RQIA Mental Health and Learning Disability Team:

Appendix 2 – Inspection Findings

The Inspection Findings contained within this report is an electronic copy. If you require a hard copy of this information please contact the RQIA Mental Health and Learning Disability Team:

Contact Details
Telephone: 028 90517500
Email: Team.MentalHealth@rqia.org.uk

Appendix 1

Follow-up on recommendations made following the announced inspection on 9 September 2013

No.	Reference.	Recommendations	No. of times stated	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1		It is recommended that soundproofing work is undertaken.	2	Inspectors reviewed the ward's main office and quiet room. Neither room had been sound proofed. Conversations held within both rooms could be overheard from the main patient day area. The ward manager stated that a request to have both rooms soundproofed had been forwarded to the Trust's estates department in 2013. The manager reported that this work had not been completed. An inspector contacted the Trust's estates department to clarify the current position regarding soundproofing. The inspector spoke to an estates officer. The officer was unable to inform the inspector regarding the commencement/completion of soundproofing within the ward.	Not met
2		It is recommended that the recording of minutes of patients meetings are reviewed and displayed where all patients and ward staff can view them.	2	Inspectors reviewed minutes from the ward's patient/staff meetings. Inspectors noted that the last meeting had been held on the 8 February 2015. Minutes from this meeting had been posted on the ward's main notice board located in the patients' day area.	Fully met
3		It is recommended that the provision of ward based activities is reviewed to ensure that patients are aware of activities available.	2	The ward's occupational therapy (OT) timetable evidenced that OT activities were available each afternoon, Monday to Friday, and all day Thursday. Patients could attend sessions in the ward's OT room located opposite the ward's main entrance.	Fully met

				Patients who met with inspectors reported that they could attend the activities should they chose to do so. Patients also explained that they could access activities within the ward upon request. These activities included board games, books and ward based OT sessions. Minutes from the patient/staff meeting held on the 8 February 2015 evidenced discussions regarding ward routine and activities.	
4		It is recommended that the therapeutic programme available for patients is reviewed to ensure that patients on the ward have access to daily therapeutic activity.	2	Inspectors met with the ward's occupational therapist .The OT was available each day, Monday to Friday, and provided a range of activities that patients could participate in. This included arts and crafts, walking group and relaxation and anxiety management groups. Upon admission each patient was assessed by the OT and an activity plan agreed. The OT also provided assessments of patients' daily living skills as required. Patients could be referred to the Trust's cognitive behavioural therapy services. However, there were no psychology services available for patients during their admission. Subsequently, patients could not access the recommended range of psychological therapies as an inpatient in accordance with their individually assessed needs.	Partially met
5		It is recommended that trust address the environmental issues and modifications as outlined in the report following the March 1 and 2 2011 RQIA inspection to	2	Inspectors discussed the environmental concerns with the ward manager, the clinical nurse support manager and the Trust's estate services at the inspection on 11 & 12 March 2015. The ward manager reported that a proposal to address	Not met

		include; • austerity of the décor within the ward; • layout of the building which does not facilitate or enhance safe and effective practice; • broken sightlines - poor visibility of bedroom area from ward office and day space; • door locking systems - cumbersome and varied; • daylight in the bedroom area - no blackout blinds or covers over glass in fire door; • shower room and fire door difficult to open; • no phone points in dormitory area; • no night lights in dormitory area; • noisy doors in the dormitory area; • staff cannot adjust the ward temperature; • location of the seclusion area - staff feel vulnerable when in the		the previously stated recommendations had been forwarded to estates services in late December 2013. Inspectors were informed that a proposal to extend the ward's main office had been agreed and that quotes for completion of the work had been obtained. However, estate services could not provide any timeline for the completion of this work. Despite the fact that these recommendations were first made in March 2011, inspectors were unable to evidence the actions taken by the Trust to address the recommendations. Inspectors noted that the following issues had not been resolved: • soundproofing the ward's main office and the patients' quiet room; • improving sight lines between the ward's main office and the patients day space; • providing blackout curtains and a fire door curtain in the patients' bedroom area; • addressing the ward's three different systems for locking doors; • providing a phone point in the patients' bedroom area; • addressing access concerns about the difficulty in opening the shower room door and fire door; • providing bedside nightlights for patient use; • reducing noise disturbance generated when the door connecting the bedroom area to the patients' day area is opened; • increasing the space available within the ward's main office; • reviewing the location of the ward's seclusion	

		area and patients access it via the day room; ward office is too small.		room.	
6	Section 4	It is recommended that the trust ensure that the policy and procedure for staff to follow in the event procedure for staff for responding to, recording and reporting concerns about actual or suspected adult abuse is consistent with regional guidance 'Safeguarding Vulnerable Adults – A Shared Responsibility' (2010).	1	Inspectors reviewed the ward's safeguarding procedures in relation to the management of vulnerable adult concerns. Staff had completed 17 vulnerable adult referrals from the 11 January 2014. The referrals had been completed appropriately and in accordance to regional and Trust guidance. Inspectors were unable to evidence that the ward's designated officer (DO) had received 15 of the referrals. There was no VA2 to verify the referral had been received and there was no evidence of communication between the ward and the DO. Inspectors discussed their findings with the ward manager and the clinical nurse support manager. The ward manager stated that the DO maintained contact with the ward as required. Correspondence from the DO was recorded in patient files and not retained in the ward's vulnerable adult referral records. Subsequently, there was no evidence to verify that 15 of the referrals had been responded to.	Not met
7	Section 5.3	It is recommended that the ward manager introduces a system to audit records and record keeping.	1	The ward manager had introduced the Trust's 'Patient safety mental health audit' tool. The tool was used on a monthly basis to ensure that care practices regarding multi-disciplinary team meetings, risk assessment and treatment and care planning were completed in	Fully met

				accordance to Trust and best practice standards. The ward manager informed inspectors that any deficits identified as a result of audit were discussed with staff and quickly rectified.	
8	Section 5.3	It is recommended that the ward manager reviews the ward routine to ensure that the routine for each patient is based on individual assessment and needs, gives consideration to the patient's human rights and is clearly documented within the patients care documentation.	1	Care records reviewed by inspectors evidenced that each patient had received a comprehensive assessment, a risk assessment and a care plan. Care plans were reviewed as required by nursing staff and on a weekly basis by the ward's multi-disciplinary team. Inspectors were concerned that the ward implemented a number of blanket restrictions. Inspectors evidenced the door to the patients' dining area and the door to the quiet room/activity area remained locked for significant periods. Inspectors were also informed that the door allowing patient access to the garden was locked for 45 minutes each hour. Patients could access these areas upon request to staff. However, inspectors could not evidence a rationale as to why the doors were locked. Patients' personal items including makeup, hairdryers, mobile phones and headphones were locked in drawers located in a room some distance from the patients' bedroom area. Inspectors were concerned that patients could not independently or easily access personal locked storage. A rationale regarding the removal of personal items was not reflected in patients' individual care plans.	Not met
9		It is recommended that the	1	A copy of the Deprivation of liberty safeguards (DOLS)-	Partially met

		trust ensures that Deprivation of Liberty Safeguards (DOLS) – Interim Guidance, as outlined by the DHSSPSNI in October 2010, is implemented within Inver 1.		Interim Guidance was available in the ward's main office and on the Trust's intranet. Each set of patients care records contained a deprivation of liberty care plan in relation to the ward's locked door environment. The care plan was prepopulated and explained that the use of a locked door environment was required for the patient's safety and the safety of others. Inspectors were unable to identify a rationale as to why a number of the ward's internal doors remained locked. The ward's dining area was locked, the patients' quiet room was locked when not in use and the door to the ward's garden area was also locked for significant periods. Two patients informed inspectors that the door was locked for 45 minutes every hour. Inspectors discussed this with the ward manager. The manager explained that patients could access the garden area upon request and the door remained locked when the garden was not being used. Although patients could access these areas upon request to staff the use of internal, including the door to the garden, locked doors was not reflected in patient care plans. A rationale for the removal of a number of patients' personal items such as mobile phones, makeup and CD/MP3 players was not reflected in patients' care records. For example, one patient was receiving two cigarettes each hour and one glass of coke. Staff explained that this was part of the patient's treatment plan to support a reduction in smoking and weight loss.	

				Inspectors were informed that this plan had been agreed by the multi-disciplinary team. However, this was not reflected in the patient's care plans.	
10		It is recommended that the ward manager ensures that care plans in relation to actual or perceived deprivation of liberty are reviewed to ensure that an explanation of deprivation of liberty is included and relevant to the plan of care.	1	Inspectors reviewed five sets of patient care records. Care plans in relation to deprivation of liberty were available. The care plans related to the ward's locked door environment and arrangements for patients admitted in accordance to the Mental Health (Northern Ireland) Order 1986. Inspectors were unable to evidence care planning in relation to a number of care practices, the removal of patients' personal property and the use of internal locked doors. One patient was noted to be receiving their cigarettes and a soft drink under supervision and at the discretion of staff. The ward manager informed inspectors that this restriction had been agreed by the multi-disciplinary team in accordance to the patient's assessed need to reduce smoking and control their diet. This intervention was not reflected in the patient's care plan. Patients' property including cigarettes and makeup was removed and stored in the patient's door located in a locked side room opposite the ward's main office. Patients could access their property upon request. However, the removal of these items was not reflected in the patient's care plan and inspectors could not evidence a rationale as to why certain personal property was retained by staff.	Not met

				Inspectors noted that a number of the ward's internal doors remained locked. The doors that were locked included the door to the dining area, the door from the patients' main living area to the corridor where the shower room and entrance to the dining room where located. The door to the ward's garden area was also locked for 45 minutes every hour. Patients could access these areas upon request to staff. The ward manager explained that the rationale for locking internal doors was to assure patient safety. This rationale was not available in patient care records or within the patient information folder/booklet.	
11	Section 8.9 & 8.14	It is recommended that the trust review the composition of and clinical specialities available within the multidisciplinary team and availability of psychotherapeutic interventions to ensure that patients on the ward have access to the full range of evidence based therapeutic interventions to meet presenting needs.	1	Patients on the ward could access occupational therapy support daily Monday to Friday. The OT provided a range of activities and therapeutic interventions. These included anxiety management and relaxation groups. Patients could access the ward's OT room and patients who were ward based were provided with support from the OT. Inspectors were informed that patients could not access psychology services during their admission	Not met
12	Section 5.3	It is recommended that the trust ensure storage area for patient property is enhanced so that patients can view their belongings while staff are accessing	1	The ward manager informed inspectors that they had forwarded a request to the Trust's estates regarding the storage area where patients' property was kept. Inspectors reviewed the area. The room was long and narrow and had a door at either end. It appeared to be	Not met

		them.		a hall connecting the main corridor to the corridor where the entrance to the seclusion room was located. Inspectors were informed that the room was only accessible via the door located at the ward's main entrance. Inspectors noted that the room had limited space and patient property was kept chests of drawers. Each patient had their own drawer. Patients could view their belongings and could enter the room under staff supervision. However, the storage area had not been enhanced.	
13	Section 5.3	It is recommended that the trust review the geographical location of patient property and clothing in relation to the sleeping area on the ward.	1	Inspectors were unable to evidence that the Trust had reviewed the geographical location of patient property and clothing. The ward manager informed inspectors that they had raised this recommendation with the Trust's estates department in October 2013. Inspectors spoke with the Trust's estates department. An estates officer confirmed that a works request had been received from the ward regarding the ward's main office. Inspectors were unable to confirm when work would commence.	Not met
14		It is recommended that the trust consider the provision of a locked facility on the ward for patients to independently securely store their personal belongings.	1	Patients had access to a locked drawer and a locked wardrobe where they could store their personal property. Inspectors were informed that access to these areas was controlled by staff. Patients could not access personal locked storage. Inspectors were unable to evidence Trust plans in relation to the provision of personal locked storage for patients on the ward.	Not met
15	Section 4.3	It is recommended that the	1	Nurse training records reviewed by the inspectors	Partially met

		ward manager ensures that all staff working on the ward undertake all mandatory training appropriate to their role.		evidenced that the ward manager continued to monitor training for nursing staff. The inspector noted that 83% of nursing staff had completed up to date managing actual and potential aggression training, 89% of nursing staff had completed up to date CPR training and 89% of nursing staff had completed safeguarding vulnerable adults training. Inspectors noted nurse mandatory training deficits in relation to COSHH training, moving and handling training, infection control training and fire training. It was good to note that 13 staff had been booked to complete COSHH training on the 30 March 2015. However, 7 staff required moving and handling refresher training, 8 staff required infection control refresher training and 7 staff required up to date fire training. Inspectors met with the Trust's mental health education and training nurse lead. Inspectors were assured that training deficits were being addressed and staff would be completing the required training in the near future. The ward's nurse training records evidenced that the deficits had been noted and that future training dates in relation to COSHH, information governance and CPR had been organised and were due to be delivered before the end of March 2015.	
16	Section 2	It is recommended that the Trust ensure that a system is put in place so that the ward manager/nurse in	1	Inspectors met with the Trust's mental health education and training nurse lead. Inspectors were informed that prior to commencing duties on the ward bank staff were required to be appropriately trained to ensure that they	Fully met

		charge can ensure that bank staff have the appropriate training skills and knowledge to work on the ward.		could meet the needs of patients. The nurse lead stated that all bank staff allocated duties on the ward had received managing actual and potential aggression (MAPA) training and the required mandatory training. Inspectors were told that the nursing co-ordinator and bank shift manager ensured that only staff appropriately training could complete bank shifts on Inver 1.	
17	Section 8.1	It is recommended that the ward manager develops a procedure to ensure that compliments are recorded and captured.	1	The ward manager retained a compliments book. The book contained a number of compliments from patients and relatives. Staff and patients could access the book as required and inspectors were informed that compliments received by the ward were also recorded in the ward's daily return records.	Fully met
18	Section 8.1	It is recommended that the ward manger develops a procedure to document locally resolved complaints.	1	Inspectors discussed the system for managing locally resolved complaints with the ward manager. The manager detailed that the ward had not received a local complaint in some time. When a local complaint is made and resolved the circumstances and outcome of the complaint are forwarded to the ward's senior nurse management team. A complaints file is kept by the team and shared with ward staff as required. Locally resolved complaints are also recorded in the patients care records and in the ward's daily briefing records.	Fully met
19	Section 5.3	It is recommended that the ward manager ensures that all care documentation is in	1	Patient nursing care records were noted to be up to date and reviewed on a regular basis. Patient assessments, risk assessment and care plans were available, legible	Fully met

		keeping with relevant published professional guidance documents including NMC Record keeping guidance.		and completed in accordance to NMC record keeping guidance. It was good to note that the ward manager completed a monthly audit of patient care records.	
20	Statements 3;8;11	It is recommended that risk assessments and care plans are discussed with the patient and if appropriate their carer. This should be evidenced within the care documentation.	1	Inspectors met with each of the patients admitted to the ward. Patients reported that they had been involved in their treatment and care. Patients could attend their multi-disciplinary team meeting and patient progress records evidenced that staff had discussed risk assessments and care plans with each patient. Inspectors reviewed five sets of patient care documentation and noted that patient and staff signatures were available when required. It was good to note that in circumstances where a patient had been unable to or had refused to sign their care documentation this had been recorded.	Fully met
21		It is recommended that all substances on the ward are stored in accordance with Control of substances hazardous to health (COSHH) regulations.	1	Inspectors reviewed the ward's procedures in relation to the management of substances hazardous to health. Substances were being managed in accordance to (COSHH) regulations. This included ensuring that hazardous substances were appropriately stored.	Fully met
22	Section 5.3	It is recommended that the trust liaise with patients in Inver 1 to review the quality, quantity and choice of food available to patients on the ward.	1	Patients who met with inspectors reported no concerns regarding the variety and quality of food provided on the ward. The hospitals kitchen staff liaised with patients on a regular basis. It was positive to note that the ward's cook visited the ward each week to meet with patients to discuss compliments and concerns.	Fully met
23	Section 6.3	It is recommended that the	1	Inspectors reviewed the ward's garden fence and noted	Not met

		trust enhance the fenced outdoor area in Inver 1 to ensure that patient privacy and dignity is not compromised		that patient privacy was being compromised. The garden located at the back of the ward had a twelve foot high rigid mesh fence. The fence offered no privacy, and patients using the garden were visible to anyone in the immediate vicinity. This included members of the public walking their dogs within the hospital grounds.	
24		It is recommended that the trust ensure that the discharge of all patients from hospital, including those who do not wish to be discharged from hospital, is managed in such a way so that patient's human rights, dignity and choice are upheld.	1	The Trust's admission and discharge policy was reviewed and noted to be appropriate and up to date. In circumstances where a patient does not wish to be discharged the ward's multi-disciplinary team (MDT) agreed a discharge plan in consultation with the patient and involved the ward's advocate with the patient's consent. If a resolution cannot be achieved by the MDT and the patient the Trust's legal services and further independent review is sought. The inspector was informed that the majority of patients discharged from the ward are transferred to other facilities prior to being discharged from hospital.	Fully met

Follow-up on recommendations made at the finance inspection on 2 January 2014.

Appendix 1

No.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	It is recommended that the ward manager ensures that a record of all staff who obtain the key to the cupboard where patients' money is held including the reason for access	The key to the locked storage where patient's money was kept was retained by the charge nurse. Staff accessing the locked storage area completed a ledger which recorded the name of the staff member and the date, time and reason the storage area was accessed.	Fully met
2	It is recommended that the ward manager ensures that appropriate systems are put in place to record purchases made by staff on behalf of patients with related receipts. Appropriate, detailed and verified records of transactions must be maintained.	The ward's patient monies receipt book recorded purchases made by staff on behalf of patients. The receipt book recorded patient signatures when money was given to a staff member and when change was returned. The receipt book also contained a shop receipt evidencing the item(s) purchased.	Fully met
3	It is recommended that the ward manager ensures that records of purchases made, and change returned to patients following outings are maintained along with appropriate receipting processes.	Money retained by the ward on behalf of a patient was recorded in the ward's patient monies record book and kept in a secure drawer in the ward's main office. The receipt book evidenced that withdrawals and lodgements of patients' monies was witnessed by two staff and the patient. The receipt book recorded purchases made by patients during outings. Inspectors reviewed the book and noted that change and receipt(s) of purchases were signed back into the book upon the patient's return. Receipts were returned to the patient upon their discharge or when the patient had been assessed as having the capacity to manage their own finances.	Fully met
4	It is recommended that the ward manager ensures that a record of purchases made on behalf of patients is reconciled with cash ledger withdrawals	The patients' monies record book evidenced that two members of staff recorded when a patient's money was withdrawn and lodged in the secure cupboard. When patients attended a ward outing or went shopping ward	Fully met

		staff recorded the amount withdrawn, the amount returned and the balance retained on behalf of a patient. During the inspection it was noted that the receipt book had been completed appropriately and in accordance to the ward's procedures and the Trust's policy.	
5	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.	Withdrawals and lodgements from the ward's money drawer are recorded in the cash ledger time the drawer is opened. The charge nurse retains responsibility for ensuring that entries in the ledger are checked and accurately reflect the amount of money held for each patient. The ward manager completes random checks of the cash ledger and the cash drawer. Any discrepancies or mistakes noted are with the relevant charge nurse.	Fully met
6	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 reviewed the ward's procedures for supporting patients making a lodgement and withdrawal from the hospital's cash office. Inspectors were informed that the cash office provided lodgement and withdrawals receipts to verify patient transactions. Inspectors were informed that upon discharge from hospital each patient received a statement from the cash office. The statement recorded all transactions completed by the patient.	Fully met

R3

For approval

The Regulation and Quality Improvement Authority

Quality Improvement Plan

Unannounced Inspection

Inver 1, Holywell Hospital

Northern Health and Social Care Trust

11 and 12 March 2015

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

The specific actions set out in the Quality Improvement Plan were discussed with the ward manager, a senior manager and nursing staff 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.

emailed 5/5/15 ✓ MCM

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
1	Section 5.3.1 (e)	It is recommended that soundproofing work is undertaken.	3	30 June 2015	work will be completed by 30/06/15 to provide adequate sound proofing.
2	Section 5.3.3 (f)	It is recommended that the therapeutic programme available for patients is reviewed to ensure that patients on the ward have access to daily therapeutic activity.	3	30 June 2015	Therapeutic programme has been reviewed to include a wide range of therapeutic activities including suggestions from patients..A notice has placed on the patients information board stating what activities are available and activies will only be postponed as a last resort.
3	Section5.3.1(e)	It is recommended that Trust address the environmental issues and modifications as outlined in the report following the March 1 and 2 2011 RQIA inspection to include;	3	30 June 2015	.All of the actions detailed in this section will be completed by 30/06/15.

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
		• austerity of the décor within the ward; • layout of the building which does not facilitate or enhance safe and effective practice; • broken sightlines - poor visibility of bedroom area from ward office and day space; • door locking systems - cumbersome and varied; • daylight in the bedroom area - no blackout blinds or covers over glass in fire door; • shower room and fire door difficult to open; • no phone points in dormitory area; • no night lights in dormitory area; • noisy doors in the dormitory area; • staff cannot adjust the ward temperature;			Ward manager has liaised with OT staff regarding suitable art décor for the bed area. This is now work in progress. Ward office is to be relocated to the Quiet Room. Costings are being sought from Building Contractor. Estimated cost 13k. An obscure film has been placed on the windows and the door providing access to the ward. Fob system to be extended to the dining room/patio and fire escape doors. Minor works submitted. Fire Officer to sign off on fire escape door and estates currently costing and preparing timetable Black out blinds have been ordered and we are awaiting confirmation date for delivery Vent in high level glazing or wall being sourced and costed. To reduce air tightness in the room

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
		• location of the seclusion area - staff feel vulnerable when in the area and patients access it via the day room;ward office is too small.			thus leaving the door easier to open. The fire door issue will be addressed in the extention of the fob system within the ward. Phone has been relocated to the 'patients area' room where privacy can be assured for phone calls. Approved lights to be installed – awaiting cost from electrical contractors. Repair to push button door access control has been completed whilst a permanent replacement is obtained. Rubber panels have been inserted to soften sound Procedure has been explained to all ward staff in relation to having temperature adjusted in the ward Bleeps are in place, staff in monitoring room will be checked regularly by the nurse in charge.

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
					Visibility has been improved with the dayroom door now kept open. Monitoring room is locked from the inside .
4	Section 5.3.1 (c)	It is recommended that the Trust ensure that the policy and procedure for staff to follow in the event procedure for staff for responding to, recording and reporting concerns about actual or suspected adult abuse is consistent with regional guidance 'Safeguarding Vulnerable Adults – A Shared Responsibility' (2010).	2	Immediate and ongoing	Safeguarding information is accessible in the nurses office. Staff are aware and able to access safeguarding information on the staff intranet. On receipt of the Core Data sheet and DO referral form an acknowledgement is forwarded to the ward which is held in the patient's notes. On completion of the VA minutes and relevant information is copied to the individual's notes and the ward is informed.
5	Section 5.3.1 (a)	It is recommended that the ward manager reviews the ward routine to ensure that the routine for each patient is based on individual assessment and needs, gives consideration to the patient's human rights and is clearly documented within the	2	Immediate and ongoing	Guidelines regarding ward routines is displayed on the patient notice board, there is flexibility for individual patient's assessed needs to be facilitated. Human rights are considered and the least restrictive intervention proportionate to the level of risk to be managed, will be discussed with the patient, implemented and reviewed regularly.

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
		patients care documentation.			This will be recorded in the patient's care plan and ongoing record.
6	Section 5.3.1	It is recommended that the Trust ensures that Deprivation of Liberty Safeguards (DOLS) – Interim Guidance, as outlined by the DHSSPSNI in October 2010, is implemented within Inver 1.	2	Immediate and ongoing	DOLS guidelines is available for staff to refer to and has been implemented in Inver 1. Ward Manager has addressed the issues identified – DOL issues are fully considered throughout, care plans, assessment, and reviews. As part of the recovery focus training staffs' awareness is enhanced
7	Section 5.3.1(a)	It is recommended that the ward manager ensures that care plans in relation to actual or perceived deprivation of liberty are reviewed to ensure that an explanation of deprivation of liberty is included and relevant to the plan of care	2	Immediate and ongoing	Care plans are individualised in collaboration with the patient. These include reference to deprivation of liberty , are reviewed as required with the patient's involvement which are then signed by both.
8	Section 5.3.3(d)	It is recommended that the Trust review the composition of and clinical specialities available within the multidisciplinary team	2	Immediate and ongoing	Patients are referred to Psychology where appropriate. Training has been provided in WRAP ,

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
		and availability of psychotherapeutic interventions to ensure that patients on the ward have access to the full range of evidence based therapeutic interventions to meet presenting needs.			Management of Depression, Anxiety Management/Relaxation Therapy. This has enabled staff to provide a wide range of activities for their patients.
9	Section 5.3.3(a)	It is recommended that the Trust ensure storage area for patient property is enhanced so that patients can view their belongings while staff are accessing them.	2	30 April 2015	Patients property is risk assessed and any item considered dangerous is removed to ensure the safety of all patients. Any other property that is locked away is at the request and consent of the patient. This is reflected in the DOLS care plan which is signed by both parties.
10	Section 5.3.3(a)	It is recommended that the Trust review the geographical location of patient property and clothing in relation to the sleeping area on the ward	2	30 April 2015	Wardrobes are now in place in the patients bed areas. The patients have free access to avail of personal clothing and belongings.
11	Section 5.3.3(a)	It is recommended that the Trust consider the provision of a locked facility on the ward for patients to	2	30 April 2015	Patients have identified drawers to store personal belongings. They can store personal belongings as detailed above in their wardrobes in the bed

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
		independently securely store their personal belongings.			area. Equally any item assessed as a potential risk is kept in a locked area with the patient's agreement. Other items may also be stored in this way at the patient's request. This is recorded in the DOL care plan.
12	Section 5.3.3(d)	It is recommended that the ward manager ensures that all staff working on the ward undertake all mandatory training appropriate to their role.	2	Immediate and ongoing	Mandatory training percentages for Inver 1 MAPA update 100% CPR 96% by 18/05/15 100% ILS 100% Infection Control 100% Moving and Handling 65% Mandatory 3 yearly 94% COSHH 59 % - will be 100% by 09/06/15 Information Governance 100 %

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
					Complaints 100 % Equality and Diversity 100% Human Rights 82 % Patient monies 100% Safeguarding for Vulnerable Adults 100% Safeguarding Children Level 1 Child Protection 85%
13	Section 5.3.1(c)	It is recommended that the Trust enhance the fenced outdoor area in Inver 1 to ensure that patient privacy and dignity is not compromised	2	30 June 2015	Estate services have costed and will purchase appropriate plants approximately 4 foot high in a specified area to enhance privacy and dignity in the patio area.
14	Section 5.3.1(c)	It is recommended that the Trust reviews the use of locked doors	1	Immediate and	The door to the patio area is open throughout the day except during medication/periods when the

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
		within the Inver ward. In circumstances were it is necessary to lock internal doors patient's care plans should record the rationale for this and evidence ongoing review.		ongoing	patients are unsettled and additional staff would be required to manage increased risk. This is risk assessed at shift changes, a nurse is assigned to the area at all times and a record is maintained when the door is locked and an explanation is recorded
15	Section 5.3.1(c)	It is recommended that the multi-disciplinary team ensures that the use of restrictive practises in relation to patients' personal property is recorded in the patient's care plan. This should include a rationale as to why the restriction is necessary and detail how the restriction will be monitored and reviewed.	1	Immediate and ongoing	Restrictive practice is discussed with the MDT on a regular basis. A rationale for any restriction is recorded. Consent is obtained from the patient in applying the restriction. DOLS care plans are signed by the patient and nurse. Reviewed as date stated on the care plan. As risk changes the care plan is reviewed to ensure restriction is balanced with the level of assessed risk.
16	Section 5.3.1 (e)	It is recommended that the Trust install a sink in the ward's occupational therapy room.	1	30 June 2015	Minor works proforma completed and forwarded to estates to request installation of a sink in the OT room.
17	Section 5.3.1 (a)	It is recommended that the multi-disciplinary team (MDT) ensures that patient discharge plans	1	Immediate and	There are no direct discharges from Inver 1 except in exceptional circumstances . A transfer form is completed containing relevant information

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
		clearly document the care and treatment goals and future plans.		ongoing	which accompanies the patient. Care plans and treatment goals are shared with the receiving ward.

NAME OF WARD MANAGER COMPLETING QIP	Yvonne McElhinney
NAME OF CHIEF EXECUTIVE / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Tony Stevens 1/5/15

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

Inspector assessment of returned QIP		Yes	No	Inspector	Date
A.	Quality Improvement Plan response assessed by inspector as acceptable	✓			13-5-15.
B.	Further information requested from provider				