The Regulation and Quality Improvement Authority

RQIA

Mental Health and Learning Disability

Unannounced Inspection

Clare Ward, Knockbracken Healthcare Park

Belfast Health and Social Care Trust

11 and 12 March 2015

npm national preventive mechanism

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Contents

1.0 General Information

Ward Name	Clare Ward
Trust	Belfast Health and Social Care Trust
Hospital Address	Knockbracken Healthcare Park Saintfield Road Belfast BT8 8BH
Ward Telephone number	028 90566779
Ward Manager	Jacinta Larkin
Email address	jacinta.larkin@belfasttrust.hscni.net
Person in charge on day of inspection	Jacinta Larkin – Ward Manager
Category of Care	Male and female – acute mental health
Date of last inspection and inspection type	PEI – 28 April 2014
Name of inspector	Kieran McCormick Dr Oscar Daly

2.0 Ward profile

Clare ward is a 20 bedded mix gender unit on the Knockbracken Health Care Park site. The ward consists of two ten bedded self-contained single gender areas with a shared entrance, clinical room, visitor's room and nurse's station. The purpose of the ward is to provide on-going assessment and treatment to patients who require continuing care in an inpatient care environment. The main entrance doors to the ward are locked.

Bedrooms and bathrooms were not locked on the days of the inspection. There were separate day spaces and dining areas for patients.

The multidisciplinary team (MDT) consists of nursing staff and health care assistants, a consultant psychiatrist, a GP, an occupational therapist (OT) and a social worker.

There were twelve patients on the ward on the days of the inspection and eleven of these patients were detained under the Mental Health (NI) 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 Clare Ward 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 23 September 2013 were evaluated. The inspector was pleased to note that five of the eight recommendations had been fully met. Two recommendations have been partially met, one will be restated for a second time and the other will result in a new recommendation. Despite assurances from the Trust, one recommendation had not been fully implemented and will require to be restated for a second time in the Quality Improvement Plan (QIP) accompanying this report.

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

The recommendations made following the finance inspection on 7 January 2014 were evaluated. The inspector was pleased to note that all three recommendations had been fully met.

4.3 Review of implementation of any recommendations made following the investigation of a Serious Adverse Incident

A serious adverse incident had occurred on the ward on 30 June 2011. Relevant recommendations made by the review team who investigated the incident were evaluated during this inspection. It was positive to note that compliance had been achieved in relation to the one recommendation made.

Details of the above findings are included in Appendix 1.

5.0 Inspection Summary

Since the last inspection it was positive to note that the consultant psychiatrist input has improved considerably with the appointment of a new consultant who visits the ward three – four times per week, one of these visits is set aside for the multi-disciplinary meeting. The ward has a rolling programme that all patients are reviewed a minimum of once in every four weeks by the consultant. The inspector also noted that the process for acquiring bank staff with the appropriate knowledge and skills was now in place. The ward had improved the arrangements for the safeguarding of patients finances. This included providing patients with the autonomy to independently securely lock their bedroom door when not in the room.

It was positive to note that the ward was participating in a peer review process with the Royal College of Psychiatrists as part of the College Centre for Quality Improvement (CCQI).

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.

Five nursing staff met with the inspector on the days of inspection. Staff informed the inspector of the steps they took to gain patients consent to care and treatment. Patients care plans however did not provide a documented guide to all staff on how to obtain or assess consent on an individual basis or the actions to take if consent was not obtained. A recommendation has been made in relation to this.

During the inspection the inspector reviewed the care documentation for three patients' and noted the following. Care plans were individualised and person centred. Care plans had been signed by the patient and where the patient had been unwilling/unable to sign an explanation had been recorded.

Each set of patient care documentation made reference to the consideration of patients' human rights and respective articles of Human Rights legislation. Patient progress notes reflected the inclusion of patients in their care and treatment.

The ward consultant psychiatrist advised the inspector that doctors are aware of the importance and method of completing capacity assessments particularly in relation to a patient's financial capacity. The inspector reviewed in one patient's file a financial capacity assessment. A review of the records evidenced that this had been consistently reviewed with a supporting care plan in place.

The ward receives visits from an independent advocacy service. The inspector met with the ward advocate who advised that their role was to promote patients' rights and support and mediate on patients' behalf. It was positive to note that the advocate attends patients' individual MDT meetings, where appropriate.

The ward held fortnightly patient/staff meetings. A record of the meetings evidenced patients in attendance, staff in attendance, review of previous meeting minutes and matters arising.

Each patient file reviewed had an individualised and holistic comprehensive nursing assessment of needs supported by a collation of the person's history. A concern noted by the inspector from the review of patients' medical records was that there were a number of loose pages in each. The inspector was concerned that important information could be misplaced or lost. A recommendation has been made in relation to this.

In each of the three patients' files care plans and assessments clearly identified the individual's physical and mental health needs. However, each risk assessment and care plan reviewed had not been consistently reviewed and evaluated throughout the patient's admission. A recommendation has been made in relation to this. In one of the files for a patient requiring

dietician input, the patient had a swallowing difficulty, a completed and up to date Malnutrition Universal Screening Tool (MUST) assessment was not in place. The MUST assessment for another patient had not been reviewed in five months despite a 12.5kg weight loss; this was brought to the attention of the ward manager. A recommendation has been made in relation to this. The inspector noted comprehensive risk assessments had been completed and regularly reviewed. This was in accordance with the Promoting Quality Care Good Practice May 2010.

During the course of the inspection the inspector noted a profiling bed located within a side room. The inspector was advised by ward staff that the use of the profiling bed was primarily for those patients with assessed physical or mobility difficulties. The patient's care file provided a clear rationale, risk assessment and care plan. The inspector was satisfied that appropriate steps had been taken to ensure the safety and welfare of the patient.

A number of patients' medicine kardexs were reviewed. In relation to as and when required medication; there tends to be no indication for the use of the medication recorded. In relation to the records reviewed the commencement and discontinue dates of medications were not consistently recorded. A recommendation has been made in relation to this.

The inspector met with the ward OT who advised that all patients are referred to OT upon admission. In addition the OT will undertake functional assessments to include cooking, shopping, money management and community living.

The inspector reviewed samples of patients' therapeutic and recreational activity plans, completed by the ward OT. Information was displayed in relation to 'ideas for trips out'. OT assessments and reports were included in the patients' care documentation.

Patient participation in activities was recorded in patients' individual records and included the detail of patients' reaction to particular activities. There was evidence in daily progress notes of one to one session with the primary nurse. A private room was available for visits from family and friends. There was evidence in the patients' care documentation of family contact either on the ward or whilst on leave.

The inspector was advised that patients in Clare ward do not have access to inpatient psychology services. A recommendation has been made in relation to this.

The inspector was advised that the OT is based on the ward for a period of twelve months before they move to a new post. The inspector was also informed that there is no period of cross over between the outgoing and incoming OT when the change occurs. It was explained that this was part of the rotational process for OT's throughout the Trust. Staff who met with the inspector expressed concerns that the process of rotation was disruptive to the ward and to the continuity of patient care. A recommendation has been made in relation to this.

Within each patients bedroom information was displayed that informed the patient of their primary nurse, consultant psychiatrist, GP, social worker, OT and ward sister. The information sheet also advised patients of how to access advocacy services and details of the ward meetings process.

The ward operates a locked door policy; patients could leave the ward by asking staff to unlock the doors but could not independently exit the ward. Bedrooms and sleeping areas were not locked on the days of the inspection. The inspector observed patients' going on outings independently and with staff over the course of the two day inspection.

Care documentation reviewed by the inspector demonstrated that the use of blanket restrictions had been discussed and recorded in each individual patient's circumstance. This included care plans in place for locked environment, use of physical interventions, use of as and when required medications and access to smoking facilities. In addition each patient also had specific assessments and care plans in place regarding individualised restrictions. This included use of mobile phone, management of finances and temporary leave off the ward.

Care documentation made reference to the consideration of patients' human rights and respective articles. However the inspector noted in only one of the three patients files reviewed a reference to deprivation of liberty within the patient's plan of care. This was discussed with the ward manager and it was explained that an explanation of the actual or potential for deprivation of a person's liberty should be elaborated within the individual plan of care for all patients. A recommendation has been made in relation to this.

In each of the three patients' files reviewed patients' had been provided with information and the policy explained in relation to the use of mobile phones and smoking arrangements on the ward. In each case the policy had been signed by the patient.

It was positive to note that a patient subject to detention had a detention care plan in place that provided a summary of the individual's rights whilst detained. Information regarding the detention process had also been provided to the patient and had been subsequently signed by the patient. In each file reviewed the inspector evidenced that the patient had been provided with a list of items that are banned from the ward. This had been signed, dated and recorded as having been explained to the patient.

Training records reviewed evidenced that 100% of staff working in Clare ward had received up to date training in physical interventions.

Independent advocacy was provided and aimed at helping patients express their opinions and concerns. This was supported by the patient/staff meetings and the complaints procedure which provided patients with further safeguards. The inspector met with the independent advocate who confirmed, where appropriate, their attendance at patients' meetings with or on behalf of the patient.

The inspector met with the consultant psychiatrist and ward social worker who provided an explanation of the discharge process. The inspector was advised that the MDT met weekly. This provided an opportunity to review patient progress and to review those patients nearing or ready for discharge.

In preparation for discharge the MDT review the patient's history, complete any necessary assessments, this may include a social work assessment. In preparation for discharge relevant information, with consent from the patient, will be shared with the community team and/or care management. Were necessary they will be invited to an MDT meeting prior to the patient's discharge.

The ward social worker advised that once an appropriate community placement is identified then a discharge care plan will be devised. Patients' discharge may be a phased process. The ward social worker acts as the link between the family, patient and MDT. A review of patients' records evidenced regular communication with patients and relatives in preparation for discharge. The inspector noted from the review of records that the plans for discharge for those with an identified community placement a discharge care plan was in place.

The inspector met with two patients on the ward. Patients who met with the inspector reported no concerns regarding the preparation for discharge process or being able to involve their family/carer in their care and treatment. Patients indicated they had been informed of their rights and were aware of who to speak to if they were concerned or wanted to make a complaint. The patients indicated that they had been involved in their care and treatment plans, multi-disciplinary meetings and had an opportunity to see the consultant psychiatrist. None of the patients who met with the inspector expressed any concerns in relation to involvement in their care and treatment.

Details of the above findings are included in Appendix 2.

On this occasion **Clare Ward** has achieved an overall compliance level of **Compliant** in relation to the Human Rights inspection theme of "Autonomy".

6.0 Consultation processes

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

Patients	**2**
Ward Staff	**5**
Relatives	**2**
Other Ward Professionals	**3**
Advocates	**1**

Patients

Patients who met with the inspector spoke positively about the ward staff. One patient expressed a number of concerns relating to their own personal circumstances. The inspector discussed each matter with the patient and also with the ward manager. The ward manager was able to provide further information and clarity in relation to the concerns discussed.
Patients' stated:

"I really like the ward and my bedroom"

"staff are good"

Relatives/Carers

The inspector met with two relatives. Relatives who met with the inspector expressed concerns in relation to a recent Trust policy on smoking that was giving them cause for concern. The relatives explained that they were addressing this matter directly with the Trust. The relatives agreed to share their concerns with RQIA via a formal letter. Relatives that met with the inspector stated:

"Clare ward is brilliant, staff are 100% they treat our daughter like a member of the family"

"…staff keep in touch and keep us fully informed"

"…the staff are fantastic"

Ward Staff

The inspector met with five members of nursing staff. Staff stated they felt well supported and that the ward had good team work. Staff stated that there was opportunity to attend training other than mandatory subjects. Nursing staff stated that patients were well cared for.

Staff stated:

“this is a happy ward, the team works very well”

“I absolutely love where I work”

Other Ward Professionals

The inspector spoke with three visiting ward professionals over the course of the two day inspection. This included the consultant psychiatrist, ward social worker and occupational therapist. Professionals who met with the inspector provided a detailed explanation of their role and function within the ward. Each visiting professional explained their input into patient care and their individual roles in preparing patients for discharge. All professionals spoke highly of the care delivered on the ward.

Advocates

The inspector met with the independent advocate for the ward during the course of the inspection. The advocate provided a summary of their role in supporting patients on the ward. The advocate stated that they attend MDT meetings where appropriate at the request of patients. The advocate stated:

“…the ward is pro-active and encourages patients to go out and do more things, the ward sister is very pro-active”

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	19	7
Other Ward Professionals	5	2
Relatives/carers	13	3

Ward Staff

Seven questionnaires were returned by ward staff.

The inspector noted that information contained within the staff questionnaires demonstrated that staff were aware of the Deprivation of Liberty Safeguards (DoLS) – Interim Guidance. The staff members indicated that they had received restrictive practice training and were aware of restrictive practices on the ward. Examples of restrictive practices as reported by staff included “locked doors”, “banned items”, “use of as and when required medication”, “detention for assessment and treatment”, “use of MAPA” and smoking restriction. All seven staff members indicated on the questionnaires that they

had received training in the areas of human rights. Six of the seven staff indicated they had received training in relation to capacity and consent.

Six of the seven staff members stated they had received training on meeting the needs of patients who require support with communication. . All seven staff members reported that patients had access to therapeutic and recreational activities and that these programmes meet the individual patients' needs.

Other Ward Professionals

Two questionnaires were returned by visiting ward professionals in advance of the inspection. This included the ward occupational therapist and social worker. It was noted that information contained within the professional's questionnaires reflected that they were aware of the DoLS – interim guidance. One of the visiting professionals stated that they had received training in the areas of restrictive practices, human rights, capacity and consent, the other had not.

One of the two visiting professionals stated they had received training on meeting the needs of patients who require support with communication. Both questionnaires indicated that individual patients' communication needs are recorded in their assessment and care plan. Both professionals recorded that they were aware of alternative methods of communicating with patients.

Relatives/carers

Three relatives returned a questionnaire. Relative's comments included:

"the best facility to cater for his needs both emotionally and physically"

"I find staff very approachable and sympathetic"

"excellently cared for by all staff"

"staff answer questions promptly and openly"

7.0 Additional matters examined/additional concerns noted

Complaints

Prior to the inspection RQIA received a record of three complaints made between 1 April 2013 and 31 March 2014. Two complaints had been made by patients and the other by a relative. The inspector reviewed the record of complaints and compliments held on the ward and in discussion with the ward manager clarified the details. The ward manager advised that all complaints had been fully satisfied and were fully investigated in accordance with policy and procedure; this was confirmed on review of the complaint records. There were no complaints outstanding against the ward. The complaints policy and procedure was reviewed and was noted to be in date.

Adult Protection Investigations

The inspector met with the ward manager and ward social worker to discuss the safeguarding arrangements on the ward. The ward manager advised that staff were robust, thorough and effective in applying with the Safeguarding Vulnerable Adult procedures and were making appropriate referrals in accordance with policy and procedure. The ward social worker advised that that staff were appropriately completing referrals in relation to safeguarding vulnerable adult issues that arise.

The inspector was provided with an overview of the substantiated allegations. The ward manager advised that there was one ongoing investigation, regarding a patient currently on the ward. This was being managed and investigated in accordance with regional and Trust policy and procedure.

Additional concerns noted

Electronic recording system

PARIS is a patient information system on which patient records can be retained, updated and continually referenced. Currently nursing staff and other members of the MDT including the ward consultant are using the PARIS system to input information. However other visiting professionals including junior doctors' on-call, visiting GP and other visiting health professionals continue to make hand written entries into patients' files. A recommendation has been made in relation to this.

Ligatures

The inspector noted a number of potential ligature points present in communal ward facilities and also within patients ensuite bathrooms. This included the taps on the communal bath and the water taps on the wash hand basins in some but not all of the patients' ensuite bathrooms. A recommendation has been made

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 23 September 2013

No.	Reference	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	17 Section 8	It is recommended that each patient is discussed at the ward round on a regular basis.	A review of three patients' files evidenced a review of each patient a minimum of once in every four weeks at the multi-disciplinary team meeting. Outside of this process patients who require to be seen more frequently are seen and reviewed by medical staff.	**Fully met**
2	18 Section 4	It is recommended that the trust review the policy and procedure for staff to follow for responding to, recording and reporting concerns about actual or suspected adult abuse whereby all referrals are reviewed by the ward sister prior to being forwarded to the designated officer to ensure that this is consistent with regional guidance 'Safeguarding Vulnerable Adults – A Shared Responsibility' (2010).	In addition to the Belfast HSC Trust Adult Protection policy and procedure, the Trust also provided an incident management flowchart to support staff. The inspector noted staff could access information regarding the Trust's 'adult safeguarding referral pathway for psychiatric wards' and guidance on 'responding to vulnerable adult abuse concerns in the hospital setting'.	**Fully met**
3	6	It is recommended that Deprivation of Liberty Safeguards (DOLS) – Interim Guidance, as outlined by the DHSSPSNI in October 2010, is implemented within Clare ward.	The Deprivation of Liberty Safeguards (DOLS) – Interim Guidance was available. Staff who met with the inspector and the returned staff questionnaires demonstrated that staff were aware and had received training in relation to the DoLs guidance.	**Fully met**
4	6	It is recommended that the ward sister 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	The inspector reviewed three patients' care files. Patient's care files evidenced consideration of Human Rights legislation and respective articles. However the inspector noted in only one of the three files a reference to deprivation of liberty within the patient's plan of care. This was discussed with the ward manager and it was explained	**Partially met**

		and relevant to the plan of care.	that an explanation of the actual or potential for deprivation of a person's liberty should be included within the individual plan of care for all patients.	
5	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.	Patients on the ward could access occupational therapy support daily Monday to Friday. The OT and nursing staff provided a range of ward based activities and therapeutic interventions. The inspector was informed that the ward did not receive input or support from clinical psychology services.	**Not met**
6	Section 2	It is recommended that the Trust ensure that a system is put in place so that the ward manager/nurse in charge can ensure that bank staff have the appropriate training skills and knowledge to work on the ward.	The inspector was informed that only the ward manager or deputy ward manager can book and request bank staff. When booking bank staff the manager will specify the staff skill and knowledge requirements needed. This helps to ensure that staff with the necessary skills and knowledge are sent to the ward.	**Fully met**
7	Section 8	It is recommended that the trust review the electronic care record process for all disciplines to ensure that there is a continuous record of all aspects of care provided to patients on the ward.	A review of patients' records reflected that all members of the ward based multi-disciplinary team (MDT) were recording onto the Trusts electronic patient information system, PARIS. However, this was not the case for visiting professionals who continued to complete hand written records in the patients' medical files. A new recommendation has been added.	**Partially met**
8	Section 5	It is recommended that the trust review the consultant psychiatrist provision for patients in Clare ward to ensure that it adequately addresses all aspects of patient	The ward now receives consultant cover one whole day and two half days per week. The consultant can also be contacted as and when required. The ward has a designated local GP contracted by the Trust who also provides medical cover.	**Fully met**

		care and treatment and service needs.		

Follow-up on recommendations made at the finance inspection on 7 January 2014

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 staff who access the key to the patients' drawers, and the reason for access, is maintained.	The ward manager advised that patients' drawers are not managed or locked by staff. Alternatively patients are provided with a key to independently lock their bedroom therefore securing all items in the room. Patients who met with the inspector confirmed they could independently lock their bedroom.	**Fully met**
2	It is recommended that the ward manager ensures that a record of staff who access the key to the Bisley drawer, and the reason for access, is maintained.	A record of the staff that access the Bisley drawer was maintained on the day of inspection. If the drawer is accessed there is a signed record, dated by two staff and a reason for access.	**Fully met**
3	It is recommended that the Trust provides separate keys and locks for each of the patients' drawers where individual patients keep their monies and the other cupboards and drawers on the ward.	All patients have single ensuite bedrooms. Within each room patients have drawers for storage. Alternative to locking individual drawers patients who require it are provided with a key to lock their bedroom, securing all items in the room. Patients who met with the inspector confirmed they could independently lock their bedroom	**Fully met**

Appendix 1

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
2	BHSCT/SAI/11/46	Two trolleys to serve meals to patients Ward Sister to approach support services regarding the feasibility of obtaining a smaller trolley to serve meals to patients.	The inspector visited the kitchen area of the ward and noted two trolleys to service meals now in place.	**Fully met**

Quality Improvement Plan

Unannounced Inspection

Clare Ward, Knockbracken Healthcare Park

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 and other senior hospital managers 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	6.3.1 (a)	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.	2	3 July 2015	The Trust recognises the need for adequate multidisciplinary input from the clinical specialities and this is currently the subject of on-going discussion with professional leads to ensure a satisfactory outcome. In addition the newly appointed Consultant Psychiatrist for the Ward has requested a meeting with the Trust's Head of Psychology and this is taking place in June 2015.
2	5.3.1 (a)	It is recommended that the ward manager ensures that care plans in relation to actual or perceived deprivations of liberty are reviewed to ensure that an explanation of deprivation of liberty is included and relevant to the plan of care for all patients.	2	7 May 2015	The Service Area's Nurse Development Lead is visiting the ward to review care plans with each member of nursing staff.
3	5.3.1 (f)	It is recommended that the Trust ensures that all visiting professionals, complete patient progress records and reviews onto the PARIS system.	1	14 May 2015	Nursing staff will ensure that all visiting professionals will complete patient progress records and reviews onto the PARIS system. This will include on call medical staff who will have universal access to the system due to the need 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
					cover each other and their on call service.
4	4.3 (i)	It is recommended that the Trust review the ligature risk assessment for the ward and consider the replacement of the water taps on the communal bath. Also the water taps within those patients' ensuite bathrooms where taps present as a risk.	1	7 May 2015	The Ward Sister has approached the Health and Safety Department within the Trust to review their current ligature risk assessment. A capital bid is being developed for submission with regards the water taps situated across the ensuite bathrooms and communal bath.
5	8.3 (j)	It is recommended that the ward manager ensures that staff assess and document patients consent to care and treatment. This should be recorded in the patients' individual care plans.	1	Immediate and ongoing	Staff continually seek patient consent during all interactions. Patient consent and capacity will be referred to in their care plans which will be reviewed in conjunction with the patient each month.
6	8.3 (h)	It is recommended that the ward manager reviews the current storage and maintenance of patients' paper care files to ensure that information is securely stored within each patient's file.	1	Immediate and ongoing	The Consultant Psychiatrist's secretary attends the ward to assist with records management in the ward.
7	5.3.1 (a)	It is recommended that the ward manager ensures that an	1	Immediate and	A MUST assessment is completed on admission and staff have been reminded of the need 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
		appropriate risk assessment is completed and regularly reviewed for any patient with a concern related to their physical health e.g. MUST assessment. The ward manager should ensure that all patients' nursing assessments are reviewed as prescribed.		ongoing	review this weekly. Patients are weighed and have their physical observations taken using NEWS each week. Staff have also been reminded of the need to complete care plans for any physical health issues as well as careplans to address the patient's mental health and associated needs. These will be reviewed monthly.
8	5.3.1 (f)	It is recommended that medical staff ensure that a clinical indication for the use of as and when required medication is clearly recorded on the kardex. The date of commencement and discontinue of all medications should be clearly recorded on the kardex.	1	Immediate and ongoing	All medicine kardex's are reviewed at least monthly. Pharmacy job plans are also being updated to include approximately two hours per month for the reviewing of these in Clare Ward.
9	6.3.1 (b)	It is recommended that the Trust review the current process for the rotation of occupational therapists. A plan to extend the time between rotations and allow a period of cross over when rotation occurs should be considered to help reduce the	1	5 June 2015	The Occupational Therapist within the Ward is a Band 5 and is seen as a training post. In the first three years of qualifying it is important that staff gain broad experience before applying for a Band 6 OT post, thus the need for rotation on a yearly basis (which is less often than the 6 – 9 month

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
		impact on the ward and continuity of patient care.			rotation within other services).

NAME OF WARD MANAGER COMPLETING QIP	Jacinta Larkin
NAME OF CHIEF EXECUTIVE / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Martin Dillon, Deputy Chief Executive

Inspector assessment of returned QIP			**Inspector**	**Date**
	Yes	**No**		

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

A.	Quality Improvement Plan response assessed by inspector as acceptable	x		Kieran McCormick	**15/05/15**
B.	Further information requested from provider		x	Kieran McCormick	**15/05/15**