The Regulation and Quality Improvement Authority

RQIA

Mental Health and Learning Disability

Unannounced Inspection

Valencia, Knockbracken Healthcare Park

Belfast Health and Social Care Trust

29 and 30 January 2015

npm national preventive mechanism

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

Contents

1.0 General Information 3
2.0 Ward Profile 3
3.0 Introduction 4
3.1 Purpose and Aim of the Inspection 4
3.2 Methodology 4
4.0 Review of action plans/progress 6
4.1 Review of action plans/progress to address outcomes from the previous unannounced inspection 6
4.2 Review of action plans/progress to address outcomes from the previous financial inspection 6
4.3 Review of implementation of any recommendations made following the investigation of a Serious Adverse Incident 6
5.0 Inspection Summary 6
6.0 Consultation Process 12
7.0 Additional matters examined/additional concerns noted 15
8.0 RQIA Compliance Scale Guidance 16
Appendix 1 Follow up on previous recommendations 177
Appendix 2 Inspection Findings 17

1.0 General Information

Ward Name	Valencia
Trust	Belfast Health and Social Care Trust
Hospital Address	Knockbracken Healthcare Park Saintfield Road Belfast BT8 8BH
Ward Telephone number	028 90565656
Ward Manager	Donna Matson
Email address	donna.matson@belfasttrust.hscni.net
Person in charge on day of inspection	Donna Matson – Ward Sister
Category of Care	Mental Health- Patients over 65 with Dementia
Date of last inspection and inspection type	Patient Experience Interview – 11 April 2014
Name of inspector(s)	Kieran McCormick

2.0 Ward profile

Valencia is a 20 bedded mixed gender ward on the Knockbracken Health Care Park site for patients who require assessment and treatment of care needs and behaviours associated with dementia. On the days of the inspection there were 14 patients on the ward. There were two patients detained in accordance with the Mental Health (Northern Ireland) Order 1986.

The main doors to the ward were locked. Accommodation was provided in two sleeping areas with eight beds each, and four single rooms. A locker and wardrobe was provided at each bedside.

There were toilets and bathrooms along the main corridor. There was a large day space area and a conservatory. A spacious dining room displayed the day's menu and another board displayed the day, date and weather. Patients were able to walk freely about the ward and access all areas including the enclosed garden.

The ward multi-disciplinary team included: nursing staff, a consultant psychiatrist; a full time dementia nurse facilitator, who oversees the discharge and transfer process; a full-time Occupational Therapist and OT Assistant; a

dedicated speech and language therapist; a designated social worker and a full-time clinical psychologist. Patients can also access support and services, following referral, from physiotherapy, dietetics, tissue viability nurse and diabetic nurse specialist.

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 Valencia was undertaken on 29 and 30 January 2015.

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

The recommendations made following the last unannounced inspection on the 2 April 2012 were evaluated. The inspector was pleased to note that 12 recommendations had been fully met and compliance had been achieved. One recommendation had been partially met however, despite assurances from the Trust; one recommendation had not been met 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 recommendation made following the finance inspection on 7 January 2014 was evaluated. The inspector was pleased to note that the recommendation had been fully met and compliance had been achieved.

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

A serious adverse incident had occurred on this ward on 2 February 2013. Relevant recommendations made by the review team who investigated the incident were evaluated during this inspection. It was good to note that compliance had been achieved for all three recommendations.

5.0 Inspection Summary

Since the last inspection the ward has addressed a number of previous recommendations and implemented a number of positive changes. These have included:

- Improving the process for covert administration of medication;
- Communication with relatives has improved particularly when an accident or incident has occurred; and,
- Provision of an easy read display for patients regarding the ward routine and how to make a complaint was displayed. Advocacy services are available to all patients and families.

The ward was recently nominated for two awards from the Dementia Services Development Centre (DSDC).

The following is a summary of the inspection findings in relation to the Human Rights indicator of Autonomy and represents the position on the ward on the days of the inspection.

The inspector reviewed three sets of patient care documentation. Patient records evidenced that on admission each patient had received a nursing and medical assessment, and a 'Mental Health Services Older People Comprehensive Risk Management Plan' had been completed. Initial assessments included a collateral review of the patient's mood, behaviour, perception and an assessment of the patient's ability to consent to their care and treatment. Patients' progress notes reflected that patients' ability to consent to care and treatment was assessed on a daily basis at each interaction with staff. Patients' progress notes reflected the patients' right to refuse care and treatment. There was evidence of pro-active strategies used to gain patient involvement in their care and treatment.

Care plans for patients were individualised and person centred. Care plans reflected the patient's individual ability regarding decision making. Care files reviewed by the inspector had not been signed by the patient alternatively these had been signed by the nearest relative however this was not consistent throughout each file. A recommendation has been made in relation to this.

The review of care plans by the named nursed had not always been completed in each case in accordance with their prescribed time frame. A recommendation has been made in relation to this.

Staff who met with the inspector reported that they felt the ward's procedures for supporting patients who lacked capacity were appropriate and patient centred. Staff explained that they felt the multi-disciplinary team (MDT) worked effectively and decisions taken on behalf of patients were comprehensively assessed and appropriate to the needs of each patient. Staff who spoke to the inspector demonstrated their knowledge of the Human Rights legislation and the Deprivation of Liberty guidance.

Patients presented as relaxed and comfortable in their surroundings. The inspector noted that staff communicated with patients in a manner appropriate to the individual needs of each patient and provided patients with options and choices in relation to activities and meal time preferences. Staff were observed to be readily available at all times during the inspection. Staff promptly and discreetly attended to patient needs, staff demonstrated they were aware of individual patients' likes and dislikes. The inspector spent some time observing practice on the ward. Observations indicated that staff were familiar with individual patients needs and were able to respond promptly and efficiently to requests for assistance.

The ward receives support from an independent advocacy service; the advocate visits the ward twice weekly. There was evidence of advocacy involvement for individual patients who required the support of the service.

The inspector met with three relatives during the inspection, and reviewed seven inspection questionnaires returned by relatives prior to the inspection. Relatives reflected that their experiences of the ward had been positive and they felt they had been given the opportunity to be involved in decisions regarding their relative's care. Relatives advised the inspector of their

involvement in the review of care plans and the opportunity to attend MDT reviews and contribute accordingly. Relatives expressed that they felt their views and opinions were respected and valued. It was good to note that relatives reported no concerns regarding their ability to visit the ward and relatives who met with the inspector were complimentary regarding their experience of staff and the quality of care provided to patients.

Each patient had a number of physical health assessments: these included a falls risk assessment; malnutrition universal screening tool assessment (MUST); and, a pressure ulcer assessment (Braden scale).

The inspector also reviewed communication assessments for each patient. The outcomes of the assessments complimented the individual patient's communication care plan which was bespoke in identifying the individual's communication needs. Additional support with communication was available from the designated ward Speech and Language Therapist. The ward Speech and Language Therapist has recently been nominated for an award from the DSDC for creating guidance on 'Communicating effectively with a person living with dementia'.

A weekly ward round is held where each patient is reviewed by the MDT. On review of the patient the MDT completes an 'MDT weekly treatment plan' the MDT will then agree a set of actions to be completed. It was unfortunate that in each of the three files sampled the actions had not in many circumstances been allocated to an identified member of the team with an agreed time for completion. A recommendation has been made in relation to this.

Each of the three patients' file reviewed included a comprehensive functional assessment on admission completed by the ward Occupational Therapist. The OT advised that all patients admitted to the ward are referred to OT and an assessment is completed. Prior to engagement at activities the OT will complete the Pool Activity Level (PAL) assessment tool. The tool is used to identify the patient's ability to engage in activities. Following this an individual programme of activities is identified for the patient. The ward OT Assistant oversees the day to day daily activities carried out on the ward. This included a mixture of individual and group work sessions. One to one sessions provided patients with activities appropriate to their individual needs. Patients could also access one to one OT support in relation to cooking, washing and daily task skills assessment and support. The inspector noted that activities are not displayed on a daily basis to inform patients and relatives. The inspector would suggest that the OT considers this going forward.

During the inspection the inspector attended a morning music entertainment session. Patients were observed during the session to positively interact and enjoy the music. Patients' reaction to the music demonstrated a positive therapeutic outcome of the session.

Patient involvement in activities was recorded in the patients' care records. Records reviewed by the inspector evidenced that activities were provided in accordance to each patient's assessed needs.

The inspector was informed that patients were able to leave the ward with support from staff and relatives on a regular basis to attend outings and to go for walks. Staff stated that patients who spent time off the ward did so in accordance with their care and treatment needs and with the agreement of relatives/carers and the multi-disciplinary team.

The inspector noted that patients could access a piano, TV, radios, books, rummage boxes, sensory walls and an enclosed garden area located to the back of the ward. Patients could independently access the garden area; a door guard alarm was fitted to advise staff if a patient chooses to go outside.

Valencia ward receives support from a designated full time psychologist. Review of patients' records demonstrated the involvement of psychology services in the MDT management and assessment of patients. The ward psychologist advised that all patients are referred to the service on admission to the ward.

There was a ward information pack provided to patients and their relatives upon admission to the ward. The information pack contained information on the wards visiting times, information about the ward environment, information on the professional team, what to bring into the ward, laundry facilities, the advocacy service, mealtimes and information on how to make a complaint or a compliment. Relatives who spoke with the inspector demonstrated their awareness of the complaints and advocacy service.

There were two patients on the ward who had been detained under the Mental Health (Northern Ireland) Order 1986 on the days of the inspection. The inspector reviewed the file of one of the patients detained. On review of the patients file a Deprivation of Liberty care plan was in place that reflected the patient was subject to detention. The care plan was person centred and referenced the patient's rights whilst detained. It was noted that the patient had been independently referred by the Trust to the Mental Health Review Tribunal. Copies of the Law Centre (NI) leaflet 'Your legal rights in hospital' was available on the ward.

The inspector reviewed the ward training matrix which demonstrated that 13 of the 22 staff members currently working on the ward had not received training in relation to Human Rights, Capacity and Consent. A recommendation has been made in relation to this.

The inspector noted during the course of the inspection that the ward's main entrance door was locked. The locked door restrictive practice was reflected in each of the three patients care files reviewed. A Deprivation of Liberty care plan in each of the patients file reflected a rationale for the use of this restrictive practice, the care plan also made reference and consideration to the respective articles of the Human Rights legislation. The inspector spent a period of time observing activity on the ward and it was good to note that over the two days of inspection the inspector observed patients moving freely throughout the ward and into the enclosed garden area. The inspector did not

observe any patients attempting to leave the ward using the main entrance during the course of the two day inspection, the inspector would therefore suggest that the Trust continue to monitor and review the use of the locked door practice.

Patients subject to individualised restrictive practices had a clear rationale recorded in the minutes of MDT meetings, best interests meetings and individualised care plans. Each patient's individualised Deprivation of Liberty Care plan also made reference to any restrictions in place and consideration of respective Human Rights articles. Patient care records reviewed by the inspector demonstrated that the use of a restrictive practice was implemented in accordance with the patient's assessed needs and was proportionate to promoting the patient's safety and well- being.

The inspector reviewed the ward's processes for recording and reporting the use of continuous/enhanced observation with patients. The inspector reviewed the care records of one patient who was receiving continuous 1-1 observation. The inspector evidenced that the patients' needs were being managed in accordance with Trust guidance and staff had completed the required records appropriately. The inspector observed the patient over the course of the two day inspection and noted that the patient presented as being at ease, the relationship between the patient and the staff member was relaxed and supportive.

The ward social worker holds responsibility for coordinating the discharge planning process. In preparation for discharge a social history of the patient is collated. This provides an opportunity to consider the previous living arrangements for the individual prior to admission to hospital and to consider the most suitable accommodation on discharge. The patients' potential for discharge is reviewed at the weekly MDT ward round. Within the first 4-6 weeks of admission a family meeting is held with the closest relatives and the MDT. It is at this meeting that the views of the family are gathered in consideration of meeting the individual's needs upon discharge. Families are provided with advice and guidance on services to consider to meet their loved ones needs upon discharge. The ward MDT and the community care manger continue to joint co-ordinate and liaise with the family and patient in order to best prepare the patient for discharge. The social worker advised that in preparation for discharge they and other members of the MDT including OT, SALT, Psychology, Nursing and Medical will complete an individualised comprehensive discharge summary. This helps to support the discharge process and aims to optimise on a successful discharge to the community.

Upon agreement of discharge the Dementia Nurse Facilitator (DNF) will support and facilitate the physical discharge of the patient particularly where the individual is moving to a residential or nursing home placement. The DNF will remain involved in the review of the patient's progress for a period of two weeks post discharge. The outcomes of the monitoring post discharge are feedback to the MDT at the weekly meetings.

Relatives who met with the inspector advised that they felt extensively involved in the preparation for the discharge of their relation. Relatives expressed anxiety regarding the transition as they had been extremely pleased with the care and treatment afforded to their relative whilst in Valencia.

The ward manager informed the inspector that there were five patients on the ward whose discharge from hospital was delayed. Delayed discharges are escalated to the hospital senior management and also to the Health and Social Care Board.

The inspector noted that on the days of inspection the atmosphere within the ward was relaxed and patients presented as being at ease and comfortable in their surroundings. Nursing staff were continually available and nurse/patient interactions observed by the inspector were noted to be respectful and supportive.

Details of the above findings are included in Appendix 2.

On this occasion Valencia 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	**4**
Ward Staff	**3**
Relatives	**3**
Other Ward Professionals	**6**
Advocates	**0**

Patients

The inspector met and spoke informally with four patients during the course of the inspection. Patients who met with the inspector presented as calm, relaxed and comfortable in their surroundings. Patients were appropriately and neatly dressed. Patients were able to show the inspector some of the activities that they enjoyed doing. This included participation in the music entertainment provided on the day of inspection, feeding the birds and trying on jewellery. Patients were observed to be walking freely about the ward or sitting comfortably with ward staff in communal areas.

Relatives/Carers

The inspector met with three relatives during the inspection. All relatives spoke highly of the service, describing the staff as “going above and beyond their call of duty”. Relatives who spoke to the inspector also stated that staff kept them well informed about their relatives care. One relative stated “I have no concerns regarding my father’s care”.

Ward Staff

The inspector met with three nursing staff on the ward. All three staff stated they felt well supported and that the ward manager was approachable. Staff advised the inspector that they had regular training and development opportunities. Nursing staff stated that patients were well cared for and that all patients are treated as individuals, staff stated that they really enjoyed working on the ward. Staff who met with the inspector expressed concerns regarding the staffing levels on the ward. The inspector discussed this matter with the ward manager and service managers. Details of ward staffing are detailed later in the report.

Other Ward Professionals

The inspector met with six visiting ward professionals over the course of the two days. Professionals who met with the inspector were able to provide an

explanation as to their role and function within the ward. Professionals were also able to provide a summary of their perception of how the ward was performing. The ward based Occupational Therapist (OT) provided a detailed overview of the recreational and therapeutic activities that take place on the ward, their involvement in assessment and planning, and the role they have in the discharge planning process. The OT spoke positively regarding the care and treatment delivered to patients on the ward.

The designated Social Worker provided a detailed overview of their involvement in assessment and planning for discharge. The Social Worker spoke positively regarding the care and treatment delivered to patients on the ward. The social worker advised that they had no concerns in relation to staffs' responsiveness to safeguarding vulnerable adult concerns and stated staff were highly vigilant. Prior to the inspection RQIA were informed that there were no safeguarding vulnerable adult referrals or investigations made during the period of 1 April 2013 and 31 March 2014. The designated social worker advised that there were currently no safeguarding vulnerable adult investigations at present.

The inspector also spoke with the ward Consultant, Speech and Language Therapist and Clinical Psychologist. Each health care professional provided the inspector with a summary of their roles, functions and involvement in patient care. Professionals were able to demonstrate to the inspector their involvement in the multi-disciplinary planning for care, treatment and discharge. Professionals stated that staff were responsive to patients changing needs and that a person centred approach was adopted on the ward.

Advocates

There were no advocates available to meet with the inspector on the days of the unannounced 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	23	9
Other Ward Professionals	5	3
Relatives/carers	12	7

Ward Staff

Nine questionnaires were returned by ward staff

The inspector noted that information contained within the staff questionnaires demonstrated that all nine members of staff were aware of the Deprivation of Liberty Safeguards (DOLS) – interim guidance. Five of the nine staff members had received restrictive practice training and were aware of restrictive practices on the ward. Examples of restrictive practices as reported by staff included "main front doors are locked", "use of bedrails", "TABs Monitors" and "1:1 observations". Seven of the nine staff members indicated they had received training in the area of Human Rights. Three of the nine staff had received capacity to consent training.

All nine staff members reported that patients had an individual assessment of their communication needs and that alternative methods of communication are used in the care setting. All nine staff questionnaires indicated that patients had access to therapeutic and recreational activities and that these programmes meet the patients' needs. Staff questionnaires also stated:

"Valencia carry out a high level of care with each patient. Unfortunately with staff absence this can be compromised"

"very person centred with family involvement"

Other Ward Professionals

Three questionnaires were returned by ward professionals in advance of the inspection. It was noted that information contained within the professional's questionnaires demonstrated that all three professionals were aware of the Deprivation of Liberty Safeguards (DOLS) – interim guidance. None of the three professionals had indicated that they had received training in restrictive practices. Two professionals indicated they had received training in the areas of Human Rights and all three staff had received training on capacity to consent.

All three ward professionals stated they had received training on meeting the needs of patients who require support with communication. All three staff indicated that patients' communication needs are recorded in their assessment and care plan. Professionals recorded that they were aware of alternative methods of communicating with patients. All professionals stated that these were used in the care setting and that the ward had processes in place to meet patients' individual communication needs. All three ward professionals reported that patients had access to therapeutic and recreational activities and that these programmes meet the patients' needs. One of the questionnaires stated:

"care provided in Valencia is person centred and is tailored to each individual's needs, there is excellent communication between staff and patients"

Relatives/carers

Seven relative questionnaires were returned prior to the inspection. All seven questionnaires rated the treatment received by their relative as 'excellent'. Relative's comments included:

"staff in Valencia ward are exceptional both to the patient and the family"

"I am overwhelmed at the care my aunt has received in Valencia, the staff are courteous and always professional, they always treat my aunt with dignity and respect. The nursing staff are a credit to the profession"

"the staff are to be highly commended"

"the care our father has received has been first class, we know our father is getting the best possible care, we know he is safe, warm, loved and cared for and this means a lot to us"

"I could not wish for a better environment, I am happy with the commitment the staff have to patients, they are caring, sympathetic and always willing to have a chat with relatives"

"I can only commend the staff on this ward for their high level of care and attention"

7.0 Additional matters examined/additional concerns noted

Complaints

Prior to the inspection RQIA were informed that no complaints had been made during the period of 1 April 2013 and 31 March 2014. The ward manager advised that there were currently no complaints under investigation. The inspector reviewed the complaint records and confirmed this to be the case.

Staffing levels

Prior to the inspection RQIA received concerns expressed on one of the staff questionnaires in relation to the ward being short staffed due to staff sickness. Staff that met with the inspector on the day of inspection also expressed concerns regarding the ward staffing levels. The inspector reviewed the staff rota for the week of the inspection and the week prior to the inspection. In addition the inspector discussed the concerns expressed by staff with the ward manager and the assistant service manager. Both managers advised the inspector that staff absence is managed through the trust attendance management policy. The managers reassured that there were no issues in approving the use of additional staff, bank staff or agency staff. Managers also reassured that they had no concerns regarding staffing and that they did not feel that patient care and safety had been compromised at any time.

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 interview inspection on 2 April 2012

No.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	It is recommended that the ward manager reviews training records to identify gaps in knowledge and skills and arranges training to address these gaps.	The ward manager advised the inspector that individual staff training is reviewed at each employee's bi-annual supervision and at their annual appraisal. The inspector reviewed the supervision, appraisal and training matrix; this indicated regular supervision, appraisal and a rolling programme of mandatory training for all staff. The inspector was provided with a copy of staff supervision and appraisal record. The inspector was also advised that if the ward manager identifies a particular member of staff with performance concerns, then additional training and support will be provided.	Fully met
2	It is recommended that staff are trained in the implementation of a policy and procedure and their specific individual responsibilities in relation to covert administration of medication.	The ward manager advised that training on the management of covert administration of medication is provided at ward level. The inspector reviewed the induction pack for Registered Nurses. The induction evidences that the use of covert administration of medication is included on Day 5 of the induction. Registered nurses that spoke with the inspector advised that they had received advice and guidance in relation to covert administration of medication and were also able to advise the inspector of the policy and procedure associated with this.	Fully met
3	It is recommended that guidance documentation in relation to definitions and types of abuse and required staff responses to concerns about abuse is displayed in staff areas.	The regional adult abuse guidance was available and displayed in the staff office. In addition to this the ward has a separate Safeguarding Vulnerable Adult folder. Included within the folder were local, regional and national guidance documents and associated policies and procedures. Easy to read information on Safeguarding Vulnerable Adults was also included.	Fully met
4	It is recommended that the ward manager ensures that all staff have read and understood local and regional policies, procedures and guidance documents in relation to protection from abuse.	Attached to the Safeguarding Vulnerable Adult policy and procedure was a signature sheet. This had been signed and dated by members of the staff team.	Fully met
5	It is recommended that the weekly review form is fully completed and signed to	The inspector reviewed a sample of three patients' files. There was evidence that the weekly MDT review form had not been fully completed	Not met

	confirm agreed actions or changes to care and treatment are implemented.	on all occasions. In particular the allocation of actions had not identified those persons or person responsible for completion of an action post meeting.	
6	It is recommended that the ward manager reviews processes to ensure records demonstrate that relatives/carers are informed of all accidents and/incidents.	The inspector reviewed a sample of completed datix records relating to accidents and incidents on the ward. Datix records reviewed indicated that a relative had been updated post incident. The inspector cross referenced this with the patient's progress notes and can confirm that nurses had also documented in the patient's notes that relatives had been informed.	Fully met
7	It is recommended that a policy and procedure in relation to management of covert administration of medication is devised as a matter of urgency.	The inspector was provided with a copy of the Local Guidance on Covert Administration of Medication. The guidance had been operational since 12 April 2012.	Fully met
8	It is recommended that information for patients in relation to making a complaint is displayed in a suitable format.	An easy to read poster is displayed at the entrance to the ward. The poster provides advice and guidance on how to make a complaint and includes the photographs of the ward manager and deputy ward manager as points of contact. Information on how to make a complaint is also included in the ward welcome pack and the trust complaints leaflet is available throughout the ward.	Fully met
9	It is recommended that the ward management review the need for a formal advocacy arrangement.	The ward now receives formal contracted advocacy support from the Alzheimer's Society. Information in relation to the advocacy service is clearly displayed throughout the ward.	Fully met
10	It is recommended that relatives are provided with information in relation to access to records.	Advice and guidance for relatives on how to access records is available within the ward welcome pack. Relatives that spoke with the inspector expressed no concerns in relation to this matter.	Fully met
11	It is recommended that all care plans are reviewed to include details of any deprivation of liberty connected with provision of care and treatment in a locked environment.	In each of the three files reviewed a person centred and individualised Deprivation of Liberty care plan had been created. The care plan detailed any deprivation of liberty or restrictive practices that a patient may be subject to. Respective articles of the Human Rights legislation had been referenced.	Fully met
12	It is recommended that the requirement for patients to ask staff to unlock the door to the enclosed garden is reviewed.	The ward manager advised that the door to the garden is unlocked during day light hours. The inspector observed that the door to the enclosed garden was unlocked over the course of the two day inspection. Patients were observed accessing the garden independently and with the support of staff. A door guard alarm is fitted to the door to inform staff if a patient	Fully met

		chooses to go outside.	
13	It is recommended that policies and procedures that require review are updated as a matter of urgency, particularly Hand Hygiene, Medical Devices, Fire Safety, Discipline and Grievance, ICT Security and Special Observations policies and procedures.	The inspector reviewed each of the policies and procedures listed. The inspector can confirm that four of the policies and procedures were up to date. It is unfortunate that the ICT security and Discipline and Grievance policy and procedures were currently out of date and had not been updated. The inspector was provided a copy of the latest ICT security policy and procedure which is currently awaiting final approval.	Partially met
14	It is recommended that information for patients in relation to ward to ward routines is displayed in a format suitable to their needs.	Information in relation to the ward routine was displayed in an easy read format at the front reception to the ward. The information included times of specific events throughout the day.	Fully met

Follow-up on recommendations made following the patient experience interview inspection on 11 April 2014

No.	Reference.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	None	None	None	None

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 Bisley drawer, and the reason for access, is maintained.	The inspector reviewed the records of staff accessing the Bisley drawer. The records included the date and signatures of two staff who access the drawer. A weekly check of the drawer was also recorded and signed by two members of staff.	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
1	SAI_13_93	A checklist should be developed to compliment the falls risk assessment and to aid better documentation of interventions and the reasons for the interventions or non-intervention.	The ward manager advised that post review of the serious adverse incident, the multi-disciplinary team had reviewed the previous falls risk assessment and decided to combine the risk assessment with an additional checklist. The new tool complimented the associated care plans for those patients were there was an identified need or risk.	Fully met
2	SAI_13_93	A proforma recording the instances of falls should be developed to assist in the review of falls and in the identification of any emerging patterns.	The ward OT advised that they complete a monthly falls analysis for each patient. The inspector reviewed a sample of the analysis for three patients. In addition to this the ward manager completes a six monthly accident and incident audit this is then escalated to the assistant service manager.	Fully met
3	SAI_13_93	Assistive technology and protective equipment for wards such as Valencia should be explored to further decrease risk.	The inspector was informed that assistive technology and protective equipment is currently used on the ward. This includes TAB's monitors, door guard, nurse call system, hip protectors and bedrails. These are individually risk assessed and care planned when used.	Fully met

Quality Improvement Plan

Unannounced Inspection

Valencia, Knockbracken Healthcare Park

29 and 30 January 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 hospital personnel on the day of the inspection visit.

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

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
1	5.3.1 (a)	It is recommended that the weekly review form is fully completed and signed to confirm agreed actions or changes to care and treatment are implemented.	2	2 April 2015	The template used for MDT treatment plan has been reviewed and amended. All members of the MDT have been made aware of their responsibilities when completing this document.
2	5.3.1 (f)	It is recommended that the trust progress with the issuing of the new ICT Security policy and procedure and review as a matter of urgency the Discipline and Grievance policy and procedure.	1	26 June 2015	An email has been forwarded to the authors of the ICT Security Policy and Disciplinary and Grievance Policy, indicating this has been identified as an action of this QIP, with a request that these documents are urgently reviewed and updated. These documents are corporate documents, the review of which is not within the direct control of the service group.
3	5.3.3 (b)	It recommended that the ward sister ensures that all patients care plans are signed by the patient or in their absence by the nearest relative.	1	2 April 2015	By 2nd April the ward manager will have reviewed all existing care plans to ensure that they are signed by each patient's relatives. A new process will be implemented within the service to ensure compliance with this recommendation. The relative's information leaflet will be amended to inform relatives of the expectation that they will be involved in the care planning process and to sign

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
					care planning documentation pertaining to their relative.
4	4.3 (m)	It is recommended that the ward sister ensures that all staff receive training in Capacity, Consent and Human Rights.	1	26 June 2015	Within the main body of the inspection report the inspector provides very positive feedback on the skills and knowledge of staff relating to their understanding of capacity, consent and human rights of patients on five occasions. This would suggest the service principles reflect best practice in the care of people with dementia and the service's approach to developing staffs skills and knowledge in this area (on job learning, mentoring and reflective practice) has been effective. More formal training for staff had been identified as a training need for staff and listed on the training matrix for the service prior to the inspection. The ward manager will ensure all staff receives formal training in this area.
5	5.3.1 (a)	It recommended that the ward manager ensure that all patients care plans are reviewed as prescribed by the named nurse.	1	Immediate and ongoing	A care plan audit tool will to be used to monitor non-compliance with the service standard. The ward manager will reflect with all band 5 staff on their responsibility to review care plans on a

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
		Reviews of care plans should ensure that care plans are evaluated and that the outcome of goals is being assessed.			minimum of a monthly basis for patients for whom they act as primary nurse

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

NAME OF WARD MANAGER COMPLETING QIP	Donna Matson Manager
NAME OF CHIEF EXECUTIVE / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Martin Dillion Acting Chief Executive

Inspector assessment of returned QIP				**Inspector**	**Date**
		Yes	**No**		
A.	Quality Improvement Plan response assessed by inspector as acceptable	x		Kieran McCormick	24/03/15
B.	Further information requested from provider		x	Kieran McCormick	24/03/15