The Regulation and Quality Improvement Authority

RQIA

Mental Health and Learning Disability

Unannounced Inspection

Rathlin Ward, Knockbracken Healthcare Park

Belfast Health and Social Care Trust

4 and 5 February 2015

npm national preventive mechanism

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Contents

1.0 General Information

Ward Name	Rathlin Ward
Trust	Belfast Health and Social Care Trust
Hospital Address	Knockbracken Healthcare Park Saintfield Road Belfast BT8 8BH
Ward Telephone number	028 90565656
Ward Manager	Paul Magowan
Email address	paul.magowan@belfasttrust.hscni.net
Person in charge on day of inspection	4 February 2015, Morning – Anne Kelly, Staff Nurse 4 February 2015, Afternoon – Paul Magowan, Ward Manager 5 February 2015 – Paul Magowan Ward Manager
Category of Care	Acute Mental Health Inpatient
Date of last inspection and inspection type	PEI – 28 April 2014
Name of inspector(s)	Kieran McCormick

2.0 Ward profile

The Rathlin Ward is an acute admission ward for adult male and female patients and is situated on the Knockbracken Health Care Park site. The ward provides single room accommodation for up to 24 patients. There were 24 patients on the ward on the day of the inspection and 11 of these patients were detained under the Mental Health (NI) Order 1986. The purpose of the unit is to provide acute assessment and treatment for patients with a psychiatric illness who require care in an inpatient environment.

Patients have access to the multi-disciplinary team which includes input from nursing, psychiatry, social work, occupational therapy and psychology. Patients on the ward have access to an independent advocacy service.

The ward maintains an open door policy; on the days of inspection patients were observed independently exiting the ward.

The inspector noted the ward was welcoming. The internal ward area was well lit, well maintained, clean and fresh smelling. There were separate day spaces and dining areas for patients.

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 Rathlin Ward was undertaken on 4 and 5 February 2015**.**

Since the last inspection the ward has addressed a number of previous recommendations and implemented a number of positive changes. This has included having additional staff members trained to facilitate patient use of the gym. The new ward manager has also compiled an information guide and folder for patients and relatives; this includes information in easy read and large print format. Patients' 'Have your say' meetings which are held fortnightly now include a clearer outcome from meetings and any actions to be taken forward.

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

The recommendations made following the last announced inspection on 26 November 2013 were evaluated. The inspector was pleased to note that nine recommendations had been fully met. However, despite assurances from the Trust, three recommendations 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 30 December 2013 were evaluated. The inspector was pleased to note that all recommendations had been fully met.

Details of the above findings are included in Appendix 1.

5.0 Inspection Summary

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 the care documentation for four patients and noted the following on the days of the inspection. Information in relation to Capacity, Consent and Human Rights was available for staff and patients on the ward. Staff confirmed their knowledge of capacity to consent and informed the inspector of the steps they took to ensure patients consented to care and treatment. Staff informed the inspector of how they would know if a patient was not consenting and the steps they would then take to ensure understanding. Seven of the nine ward staff and visiting professionals questionnaires returned indicated that staff had not received capacity and consent training. A recommendation has been made in relation to this.

Care plans in the four patients files reviewed were individualised and person centred. Care plans had been signed by the patient in some instances or where they had not been signed, an explanation had been inserted; however this was not consistently evidenced in all files reviewed. The inspector was not provided with any evidence that an opportunity was provided at a later date for patients to sign their care plans where care plans had not been signed or where patients had been unable to sign. A recommendation has been made in relation to this.

It was positive to note that patients subject to detention had a detention care plan in place that provided an explanation of the individual's rights whilst detained.

The inspector noted there was no reference to patients' human rights or capacity to consent for care, treatment or invasive procedures within their care files. Care plans did not provide guidance to staff on how to obtain or assess consent on an individual basis or the actions to take if consent was not obtained. The daily progress notes made no reference that patients were consenting or not to care and treatment on a daily basis. A recommendation has been made in relation to this.

Each patient had an individualised and holistic assessment of needs upon admission completed by both a member of the medical and nursing staff; however this was not signed and dated in each case by the responsible professional. A recommendation has been made in relation to this. The inspector reviewed three comprehensive risk screening tools and one comprehensive risk assessment. The inspector noted that one of the risk screening tools had not been completed in accordance with the Promoting Quality Care Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services May 2010. There was no rationale provided as to why there was no progression to a comprehensive risk assessment or review in accordance with the guidance. A recommendation has been made in relation to this.

Patients care files did not reflect a Human Rights approach recorded within the care documentation. Four of the nine ward staff and visiting professionals questionnaires returned indicated that staff had not received Human Rights training, staff who met with the inspector confirmed that they had not received Human Rights training. A recommendation has been made in relation to this.

Patients care files reflected regular contact with medical staff and a minimum of once weekly one to one consultation with the consultant psychiatrist. For those patients that require review more regularly this is facilitated and was reflected in medical progress notes.

Four ward staff who met with the inspector demonstrated their knowledge of patients' communication needs. Staff were familiar with individual patient needs, their likes, dislikes and choices.

The inspector reviewed samples of patients' individualised assessments and plans for therapeutic and recreational activity, completed by the ward Occupational Therapist (OT). All patients admitted to the ward are referred to the OT on admission. There was a structured programme of activity displayed to advise patients and staff of the activities that would take place Monday to Friday. Patients also had their own daily schedules which they devise in conjunction with the OT department within the first week of admission. OT assessments and reports were included in the patients' care documentation; OT recommendations were included in patients' care plans. Patient participation at one to one and group therapy or activities was recorded in the daily progress notes and included the detail of patients' reaction to particular activities. Patients who spoke with the inspector advised that it can be difficult to fill time at the weekends as there was little to do on the ward. A recommendation has been made in relation to this.

Ward staff and the OT stated that staff facilitate anxiety and stress management sessions. There was evidence in daily progress notes of 1-1 nursing time spent with individual patients.

A list of names of those staff currently trained in the use of gym equipment was displayed on the ward. This included six members of the staff team. The ward provides a notice board for patients to write their name if they would like to access the gym.

The inspector observed staff actively engage with patients, communication and interactions were positive. Family and friends visiting Rathlin are welcome onto the main ward; a private room was available for visits. There was evidence in the patients' care documentation of family contact either on the ward or whilst on home leave.

The inspector was advised that patients in Rathlin can be referred to the inpatient psychology services. The inspector met with the clinical psychologist during the course of the inspection who provided an overview of their role and involvement in patient care.

Information was available for patients in relation to: complaints; independent advocacy services; keeping healthy; deprivation of liberty; capacity; and consent.

The inspector met with six patients on the ward. The 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. Information on how to make a complaint and access advocacy services was displayed in the patient communal area. Patients who met with the inspector who had been detained in accordance with the Mental Health (NI) Order 1986 advised that they were aware of the Mental Health Review Tribunal and of their rights whilst detained.

The inspector reviewed evidence of work undertaken to prepare patients for discharge. In one case this included periods of trial leave, there were recorded discussions with patients and their nearest relatives in preparation for trail leave and on subsequent return to the ward.

The inspector met with the discharge coordinator who advised that in preparation for discharge a social history of the patient will be collated. This is used to help establish if the previous living arrangements prior to admission to hospital are suitable upon discharge. Following this a social work assessment will be completed and will help identify services needed post discharge. Throughout the plan for discharge relevant information will be shared with the community team and if necessary the community team will be invited to a Multi-disciplinary Team (MDT) meeting prior to the patients discharge. In preparation for discharge input from the patient and members of the MDT including OT and psychology services will be sought. Staff advised the inspector that MDT meetings are used to track patient progress and identify those nearing discharge.

The inspector was not provided with any evidence of a formalised discharge pathway however individual patients' files evidenced completed discharge care plans and checklists for those patients whose discharge was imminent.

The ward manager advised that there were nine patients on the ward that were delayed in their discharge from hospital. The discharge co-ordinator advised that delayed discharges are escalated to the operations manager. The ward manager, consultant and discharge co-ordinator advised that the delay in patients discharge was not good for the individual and that it was proving difficult to secure appropriate community services to meet individual patient's needs.

The inspector met with six patients during the course of the inspection. None of the patients expressed any concerns in relation to involvement in their care and treatment. All patients stated they had received one to one time with their primary nurse and consultant psychiatrist.

Details of the above findings are included in Appendix 2.

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

6.0 Consultation processes

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

Patients	**6**
Ward Staff	**4**
Relatives	**0**
Other Ward Professionals	**7**
Advocates	**1**

Patients

The inspector met with six patients. Patients who met with the inspector largely spoke positively regarding time spent on the ward and also spoke positively of the ward staff. The patients also confirmed their involvement in their care throughout their admission. Patients informed the inspector about their daily activities and involvement with OT. One patient expressed that it can be difficult to fill time at the weekends. Another patient also expressed concerns regarding tea and coffee facilities outside of break times; this was discussed with the ward manager who advised that a hot drinks machine was available on the ward. In addition to this staff will make tea and coffee for if they are free and available. The same patient also expressed concerns regarding the shower facilities in their bedroom. The inspector had a look at the shower and noticed that the shower can only be used for a maximum of 3-5 minutes. In addition, when the shower is in use, the sink facilities in the en-suite are out of use. The ward manager and senior hospital managers were advised of this and agreed to report to the estates department. A recommendation has been made in relation to this.
Two patients discussed with the inspector concerns associated with their individual circumstances, in each case the inspector provided the patient with advice and guidance; the inspector also discussed the matters with the ward manager and asked that the primary nurse review the concerns with each patient. Patients who met with the inspector were satisfied with the overall care they were receiving on the ward. Patients stated:

"this is a very good place here"

"filling the day can be difficult, there are no activities in the evening or at the weekend"

"this is a great place"

Relatives/Carers

There were no relatives available to meet with the inspector on the days of the unannounced inspection.

Ward Staff

The inspector met with four members of nursing staff on the ward. All staff stated they felt well supported and that the new ward manager was approachable. The staff stated that they felt the ward had a good working team. Staff who met with the inspector expressed concerns regarding the number of delayed discharges on the ward and that the weekends can be very long. Nursing staff stated that patients were well cared for and that all patients are treated as individuals.

Other Ward Professionals

The inspector met with seven visiting ward professionals over the course of the two day inspection. 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. All professionals spoke highly of the care delivered on the ward. Visiting professionals expressed concerns regarding the prolonged discharge of many patients. They felt they were exhausting all possibilities within their own remits but that there was a greater issue outside of the hospital. Professionals stated:

“the ward manager is very good and helpful”

“staff are very pro-psychology and interested in work undertaken”

Advocates

The inspector met with an independent advocate during the course of the inspection. The advocate provided a summary of their role in supporting patients and relatives on the ward. The advocate explained that they provide a peer lead advocacy service, they facilitate 1-1 support and group sessions for carers. The advocate stated that they attend MDT meetings or meetings with consultants at the request of carers. The advocacy service works to support carers in the preparation for discharge process and can provide post discharge training courses on subjects such as medication management and carers’ resilience. The advocate stated:

“the ward can be challenging and difficult for staff, communication is key to the relationship between families and the staff team”

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	20	8
Other Ward Professionals	5	1
Relatives/carers	24	1

Ward Staff

Eight questionnaires were returned by ward staff

The inspector noted that information contained within the staff questionnaires demonstrated that five staff were aware of the Deprivation of Liberty Safeguards (DoLS) – interim guidance. One staff member 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 "1:1 observations", "MAPA" "ground pass restrictions", "patients asked to remain in their bedroom for a while for low stimulus and "locked main door on occasions". Four of the eight staff members indicated they had received or had a date scheduled for training in the areas of Human Rights and capacity to consent.

Four of the eight staff members, who returned their questionnaires prior to the inspection, stated they had received training on meeting the needs of patients who require support with communication. All staff questionnaires indicated that patients' communication needs are recorded in their assessment and care plan. Three of the eight staff members reported that patients had access to therapeutic and recreational activities and that these programmes meet the individual patients' needs.

Other Ward Professionals

One questionnaire was returned by a visiting ward professional in advance of the inspection. It was noted that information contained within the professional's questionnaire demonstrated that they were aware of the DoLS – interim guidance. The visiting professional had received training in the areas of restrictive practices, human rights, capacity and consent.

The visiting professional stated they had received training on meeting the needs of patients who require support with communication and that individual patient's communication needs are recorded in their assessment and care plan. The professional recorded that they were aware of alternative methods of communicating with patients and that these were used in the care setting.

Relatives/carers

One relative returned a questionnaire. Relative's comments included:

"We are happy with all aspects and services that are being provided"

7.0 Additional matters examined/additional concerns noted

Complaints

Prior to the inspection RQIA received a record of the number of complaints made between 1 April 2013 and 31 March 2014. The inspector reviewed the record of complaints held on the ward and in discussion with the ward manager clarified the details. The ward manager advised that all complaints had been fully investigated in accordance with policy and procedure; this was confirmed on review of the complaint records. The inspector noted that the outcome of a number of complaints were either not satisfied or were partiality satisfied. A review of evidence from the complaint records indicated that these complaints were being managed by the Trust complaints department in conjunction with senior managers from within the associated directorate.

Adult Protection Investigations

The inspector met with the ward manager, social work team leader and spoke on the phone to the social work development lead, who also acts as the designated officer for the ward, to discuss the safeguarding activity on the ward. The social work development lead advised that staff were familiar with the Safeguarding Vulnerable Adult policy and procedure and were making appropriate referrals in accordance with the policy and procedure. They advised that they had no concerns regarding staff lifting the phone and discussing any concerns.

The inspector was provided with an overview of two substantiated allegations. The ward manager advised that there was one ongoing investigation, regarding a patient currently on the ward. The social work development lead advised that protection plans were put in place if a concern was identified; however there was a concern that there was a delay in receiving referrals from ward staff for safeguarding investigations. The ward manager explained that they screen all safeguarding referrals prior to onward referral to the designated officer. A review of the Trust Safeguarding Policy provided no structured time guide for staff or the ward manager in the completion and onward escalation of a safeguarding concern. A recommendation has been made in relation to this.

Additional concerns noted

Profiling beds

A serious adverse incident resulting in a fatality concerning the use of a profiling bed as a ligature point occurred in 2013. In December 2013 The Health and Social Care Board requested that all HSC Trusts take appropriate actions in accordance with The Northern Ireland Adverse Incident Centre Estates and Facilities Alert EFA/2010/006. The exposed bed frame on the profiling beds on Rathlin presents the same level of risk associated with ligature points as was the case when the fatality occurred. A recommendation has been made in relation to this.

During the course of the inspection the inspector noted four profiling beds located within four separate single side rooms. The inspector was advised by ward staff that the bed was primarily used for those patients with assessed physical or mobility difficulties. However, ward staff advised that this bed may also be used for any patient, if it is the only bed available on the ward.

The inspector reviewed the care file for two patients who were currently occupying these beds. The inspector noted that in each care file there was no rationale, care plan or risk assessment for the use of the bed in each case. The inspector did note however that on the last day of inspection one of the patients had a care plan created during the inspection. However the care plan did not provide a rationale for the use of the bed. The matter was brought to the attention of the ward manager and senior hospital management. A recommendation has been made in relation to this.

Patient smoking area

During the course of the inspection the inspector visited the outdoor facilities for patients. On visiting the smoking area/enclosed garden the inspector noted a significantly large number of cigarette butts littered throughout the area. The ward manager and hospital managers advised that arrangements were in place with the estates department to maintain this area. A recommendation has been made in relation to this.

Electronic recording system

Rathlin ward is currently working towards having all patient care records maintained on an electronic recording system, PARIS. The inspector met with the Information System Project Manager who advised that completion of all paper records moving to the PARIS system is due to be complete for inpatient facilities by May 2015. Currently nursing staff and other members of the MDT except medical staff are using the PARIS system to input information. Medical progress notes and patient reviews continue to be hand written into patients' files. A recommendation has been made in relation to this.

Training

The inspector reviewed the training records for 24 members of the staff team. The inspector was concerned to note a significant gap in staff attendance at Infection Prevention and Control training. A review of the staff training matrix indicated that 19 (79%) of the 24 staff members were not up to date with this training. A recommendation has been made in relation to this.

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

Follow-up on recommendations made following the announced inspection on 26 November 2013

No.	Reference.	Recommendations	Number of times stated	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	Document Number:2 Section 1, number 13.5 (page 10)	It is recommended that the Nurse Development Lead and the Multi-disciplinary Team complete a review of the ward's care planning process.	1	The Nurse Development Lead (NDL) in conjunction with other professionals and departments within the Trust has progressed the implementation of electronic record keeping. The inspector was advised that the inputting of all patients MDT records including care plans onto an electronic format will be complete by May 2015. In addition to this the NDL continues to hold focus group meetings to discuss the care planning process; the inspector was able to review minutes of these meetings.	**Fully met**
2	Document Number:16 Section 5.2, (page 12)	It is recommended that patient signatures are made available on all relevant care documentation. Staff should record if they had been unable to attain a signature.	1	The review of patients' records evidenced that the patients' signatures or a reason for the absence of signatures had not been consistently recorded in any of the patient files reviewed.	**Not met**
3	Document Number:6 DOL (2010)	It is recommended that the Charge Nurse ensures that Deprivation of liberty standards are incorporated in each patients care plan.	1	Patients' care files reviewed by the inspector provided little or no reference to Deprivation of Liberty or to the Deprivation of Liberty Interim Guidance, DHSSPS 2010.	**Not met**
4	Document Number:12 Section 1.6.9 (page 24).	It is recommended that the Charge Nurse and Service Manager ensure that at least five members of the staff team are trained to facilitate patient access to the ward gym.	1	A list of names of those staff currently trained in the use of gym equipment was displayed on the ward. This included six members of the staff team. The ward provides a notice board for patients to write their name if they would like to access the gym.	**Fully met**
5	Document	It is recommended that the	1	The inspector reviewed the Trust's patient property policy	**Fully met**

	Number: 2 Section 1, 1.4 (page 1)	Trust's patient's property policy is updated.		and noted that it has been updated and is next due for review August 2017.	
6	Document Number:2 Standards 5.1- 5.26 (pages 3 – 5)	It is recommended that the Charge Nurse ensures that all staff have the opportunity to complete their mandatory training.	1	Staff training is reviewed and any individual needs are identified at supervision and appraisal sessions. Review of the staff rota evidenced mandatory training allocated to staff. In addition staff are responsible for identifying any training needs that they may have. Staff can request a course using the online booking system.	**Fully met**
7	Document Number:17 Section 4, 4.3 L	It is recommended that the Charge Nurse ensures that all nursing staff receive supervision in accordance with NMC standards.	1	A review of the supervision matrix evidenced that all registered nurses and health care assistants receive bi-annual one to one supervision and an annual appraisal session. The supervision matrix evidenced a rolling programme of supervision and appraisal for all staff. Staff that met with the inspector confirmed that they receive supervision and appraisal with their line manager.	**Fully met**
8	Document Number:2 Section 1, 7.4 (page 5)	It is recommended that all complaints are managed in accordance with Trust policy and that details of the outcomes and actions are recorded in the Ward's complaint book.	1	The inspector reviewed the Trusts complaints policy and noted that it is due for review April 2016. A review of the wards complaints folder evidenced that all local complaints and complaints received from the complaints department had been investigated and managed in accordance with the Trust's policy.	**Fully met**
9	Document Number:13 Section 4.3 (page 32)	It is recommended that the recording template for the patient 'Have your say meetings' is reviewed and that a future template details the outcomes of meetings and the actions agreed.	1	The inspector reviewed the minutes of the patients' 'Have your say' meetings. A record of the minutes evidenced the number of patients in attendance, staff in attendance, review of previous meeting minutes, matters arising and actions to be taken forward. The minutes are then signed by the person chairing the meeting.	**Fully met**
10	Document Number:2	It is recommended that the ward's clinical equipment is	1	The inspector reviewed evidence of a capital bid proposal that has been submitted for restructuring an area of the	**Fully met**

	Section 3, 27.3 (page 17)	centrally stored in the one location. Consideration should be given to relocating the staff room to facilitate this.		ward to facilitate the centralisation of clinical equipment, approval is yet to be confirmed. Following a tour of the ward the inspector noted that the ward's clinical equipment was not centrally stored; however the equipment was stored safely throughout the ward.	
11	Document Number:20 Standard 13 (page 11)	It is recommended that doors to patient rooms have broken glass panes replaced and that they provide appropriate coverings to ensure patient privacy and promote patient safety.	1	The inspector observed no broken glass panes anywhere on the ward.	**Fully met**
12	Document Number:2 Section 4, 30.1 – 30.6 (page 19 – 20)	It is recommended that the ward is repainted.	1	The ward manager confirmed that the ward has not been repainted. The inspector identified that a number of communal and private areas of the ward require urgent repainting. The inspector was informed that a capital bid for repainting of the ward has been submitted and approved. However no date of commencement or completion has been agreed, a copy of the information was evidenced to the inspector.	**Not met**

Appendix 1

Follow-up on recommendations made following the patient experience interview inspection on 28 April 2014

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

Follow-up on recommendations made at the finance inspection on 30 December 2013

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 master key and the reason for access, is maintained.	The inspector reviewed records of access to the master key. Records evidenced reasons for access to the master key this is signed and dated by two members of staff**.**	**Fully met**
2	It is recommended that the ward manager ensures that two staff open the patients' safes in accordance with the ward policy.	There is a record of two members of staff signatures each time a patient's safe is opened. The reason for opening is recorded, dated and signed.	**Fully met**

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

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

Quality Improvement Plan

Unannounced Inspection

Rathlin Ward, Knockbracken Healthcare Park

4 and 5 February 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 members of 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	5.3.3 (b)	It is recommended that patient signatures are made available on all relevant care documentation. Staff should record if they had been unable to attain a signature.	2	8 May 2015	Band 6s within Rathlin Ward continue to audit notes on a monthly basis. Any issues are highlighted to the Charge Nurse who addresses this in supervision with the staff member. The Senior Clinical Nurse Manager will also undertake random spot checks in addition to the monthly audit.
2	5.3.1 (a)	It is recommended that the Charge Nurse ensures that Deprivation of Liberty Safeguards are incorporated in each patients' care plan.	2	8 May 2015	The Charge Nurse has developed draft templates of care plans in relation to Deprivation of Liberty, Human Rights etc for staff to refer to when completing care plans for their patients. The quality of care plans is reviewed as part of the audit mentioned above.
3	5.3.1 (f)	It is recommended that the ward is repainted.	2	31 July 2015	The ward has now been repainted.
4	4.3 (m)	It is recommended that the ward manager ensures that all staff receive Human Rights, Restrictive Practice, capacity, consent and infection prevention and control training.	1	5 June 2015	Human Rights training incorporating capacity to consent and restrictive practices is available from the Clinical Education Centre. Staff will be sent on this training as places on the course become available. This recommendation will not be

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
					addressed within the stated timescale – the Trust endeavours to have all staff trained on the above by November 2015.
5	8.3 (j)	It is recommended that the Ward manager ensures that staff assess patients' consent to daily care and treatment. This should be recorded in the patients' individual care plans and continuous nursing notes.	1	Immediate and ongoing	The Charge Nurse will ensure that care plans include guidance for staff regarding consent. When the Care Plan is formally being reviewed or amended the Patients consent will be reviewed and recorded. Consent is considered during every interaction with Patients.
6	5.3.1 (f)	It is recommended that the ward manager ensures that all patients' care documentation is signed and dated upon completion by the responsible person.	1	Immediate and ongoing	Band 6s within Rathlin Ward continue to audit notes on a monthly basis. Any issues are highlighted to the Charge Nurse who addresses this in supervision with the staff member. The Senior Clinical Nurse Manager will also undertake random spot checks in addition to the monthly audit.
7	5.3.3 (b)	It is recommended that the ward manager ensures that risk screening tools are completed in full. If a decision is made not to proceed to a full comprehensive	1	Immediate and ongoing	All inpatients must have a comprehensive risk assessment completed within two weeks of the admission. The Ward Manager will ensure that this is rectified. As stated in previous

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No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
		risk assessment then a clear rationale must be recorded and signed by all relevant parties, as outlined in the Promoting Quality Care Guidance Document – Good Practice on the Assessment and Management of Risk in Mental Health and Learning Disability Services- May 2010.			recommendations an audit takes place on a monthly basis – a review of risk assessments will form part of this.
8	4.3 (i)	It is recommended that the Trust urgently review the continued use of profiling beds on the ward. The outcome of the review should be clearly reflected in the environmental and ligature risk assessment. Patients who continue to use profiling beds should have a clear rationale in their care file supported by a risk assessment and supporting care plan.	1	8 May 2015	The Trust are currently reviewing guidance sent out by the Health and Social Care Board in relation to Profiling Beds. A clear rationale will be outlined in the care plan of any patient who needs to avail of a profiling bed.
9	5.3.1 (a)	It is recommended that the ward manager ensures that all patients' care plans are reviewed as	1	Immediate and	Band 6s within Rathlin Ward continue to audit notes on a monthly basis – this will include the review of care plans. Any issues are highlighted to

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No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
		prescribed. Reviews of care plans should ensure that care plans are measured and that the outcome of goals is assessed.		ongoing	the Charge Nurse who addresses this in supervision with the staff member. The Senior Clinical Nurse Manager will also undertake random spot checks in addition to the monthly audit.
10	6.3.2 (g)	It is recommended that the ward manager develops a flexible recreational activity schedule for weekends which will consider the individual needs and views of the patients.	1	5 June 2015	The recreational activity schedule for patients at the weekend will be reviewed by nursing staff in conjunction with the ward's Occupational Therapist.
11	5.3.1 (f)	It is recommended that the estates department review the shower and wash hand facilities in en-suite bathrooms, to ensure that patients have appropriate amenities to attend to personal hygiene needs.	1	5 June 2015	The ward is actively looking to resolve this issue in conjunction with Estates Services who are currently assessing the issue.
12	5.3.1 (f)	It is recommended that the Trust review the arrangements for the maintenance of the outside garden/smoke area to ensure that the area is regularly visited and maintained.	1	5 June 2015	The Charge Nurse will contact Estates Services in relation to this issue.
13	5.3.1 (f)	It is recommended that the Trust	1	8 May	This issue has been raised with the Associate

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No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
		ensures that all members of medical staff, in line with the rest of the MDT, begin entering progress notes and reviews onto the PARIS system.		2015	Medical Director, Adult Social and Primary Care and the Clinical Director for Acute Mental Health Services.
14	5.3.2 (c)	It is recommended that the Trust review the Safeguarding policies and procedures to reflect a time guide that will assist staff in the escalation and timely forwarding of concerns for investigation.	1	5 June 2015	The Trust's Adult Protection Policy is in keeping with Trust Regional Guidance and will not be amended. Staff have been aware that ASP1 referrals should be completed and processed within 24 hours of the incident taking place.

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	Paul Magowan
NAME OF CHIEF EXECUTIVE / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Martin Dillon, Deputy Chief Executive

Inspector assessment of returned QIP				**Inspector**	**Date**
		Yes	**No**		
A.	Quality Improvement Plan response assessed by inspector as acceptable	x		Kieran McCormick	**08/04/15**
B.	Further information requested from provider		x	Kieran McCormick	**08/04/15**