The Regulation and Quality Improvement Authority

RQIA

Mental Health and Learning Disability

Unannounced Inspection

Brooke Lodge

Lakeview Hospital

Western Health & Social Care Trust

13 & 14 October 2014

npm national preventive mechanism

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Contents

1.0 General Information

Ward Name	Brooke Lodge
Trust	Western Health & Social Care Trust
Hospital Address	Lakeview Hospital Gransha Park Clooney Road BT47 6TF
Ward Telephone number	028 71 860261
Ward Manager	Lorraine Clarke
Email address	lorraine.clarke@westerntrust.hscni.net
Person in charge on day of inspection	Lorraine Feeney
Category of Care	Assessment and Treatment
Date of last inspection and inspection type	8 April 2014, Patient Experience Interviews
Name of inspectors	Wendy McGregor Audrey Woods

2.0 Ward profile

Brooke Lodge is a nine bedded ward situated in Lakeview hospital. The purpose of the ward is to provide assessment and treatment to male and female patients with a learning disability who need to be supported in an acute psychiatric care environment.

On the days of the inspection there were eight patients on the ward. None of the patients were detained under the Mental Health (Northern Ireland) Order 1986. There were four patients whose discharge from hospital was delayed.

Patients within Brooke Lodge receive input from a multidisciplinary team which incorporates psychiatry; nursing; psychology and behavioural support. Patients can access dietetics, podiatry and speech and language therapy by referral. A patient advocacy service is also available.

On the days of the inspection the ward was clean and well maintained. Patients had their own bedrooms. Bathrooms were clean and fresh smelling. There were several sitting rooms and a dining room. The ward was spacious and well lit. Signage to and on the ward was good. Patients on the ward

could access several outdoor spaces and garden areas. Patients on the ward could also access a day care facility within Lakeview hospital, where patients could avail of multi-sensory rooms, a soft play area, Jacuzzi, therapy rooms, and an art and craft room.

3.0 Introduction

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

3.1 Purpose and Aim of the Inspection

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

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

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

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

3.2 Methodology

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

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

The inspection process has three key parts; self-assessment, pre-inspection analysis and the visit undertaken by the inspector.

Specific methods/processes used in this inspection include the following:

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

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

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

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

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

4.0 Review of action plans/progress

An unannounced inspection of Brooke Lodge was undertaken on 13 and 14 October 2014.

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

The recommendations made following the last unannounced inspection on 12 February 2014 were evaluated. Inspectors were pleased to note that 8 of the 10 recommendations had been fully met and compliance had been achieved in the following areas:

- 15 out of the 16 staff had received up to date training in dealing with complaints, with a new staff member scheduled to attend training in October
- All staff had received up to date training in challenging behaviour, restrictive practices and physical interventions
- All staff had received up to date training in the protection of vulnerable adults
- The deputy ward manager and all staff had received up to date supervision and appraisal.
- A staff training and development plan had been developed for the ward all training needs are identified and actioned.
- All staff had received training and information in relation to the application of the Trust's safeguarding vulnerable adult procedures to their area of work.
- All staff had received up to date training in child protection
- Regular staff meetings were held and all staff had the opportunity to attend these.

However, despite assurances from the Trust, 2 recommendations had not been had not been met. 2 recommendations 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 patient experience interview inspection

The recommendations made following the patient experience interviews inspections on 8 April 2014 were evaluated. Inspectors were pleased to note that 3 of 7 recommendations had been fully met and compliance had been achieved in the following areas:

- All patients had access to the complaints procedure in a format appropriate to their individual communication needs.
- All patients were made aware of the wards' do's and don'ts.
- The ward was using a physical intervention monitoring form that was in keeping with Department of Health regional guidelines on the HUMAN RIGHTS WORKING GROUP ON RESTRAINT AND

SECLUSION Guidance on Restraint and Seclusion in Health and Personal Social Services AUGUST 2005

However, despite assurances from the Trust, 4 recommendations had not been fully implemented. 2 recommendations had been partially met and 2 recommendations had not been met. 4 recommendations will require to be restated for a second time, in the Quality Improvement Plan (QIP) accompanying this report.

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

The recommendations made following the finance inspection on January 2014 were evaluated. Inspectors were pleased to note that 8 of 11 recommendations had been fully met and compliance had been achieved in the following areas:

- A record of each staff member who obtained the key to safe was maintained, and included the reason for access.
- Individual transactions were fully recorded for each patient, and verified withdrawals, expenditure and change returned to the ward
- A daily check of the safe included a check of the amount of money held in the safe against the cash record on the day.
- Cash ledger records were held separately and securely from the money wallet.
- All items brought into the ward on admission were listed appropriately, the area of their storage or transfer was recorded, and appropriate receipting was undertaken, and included when relatives removed items from the ward.
- Transparent records were maintained in relation to the use of patients' monies, and included receipts for purchases and records of reconciliation of records, cash and receipts.
- All receipts were noted with the individual patient's name and held with the patient's cash records

However, despite assurances from the Trust, 2 recommendations had not been fully implemented and were not fully met. 2 recommendations will require to be restated for a second time.in the Quality Improvement Plan (QIP) accompanying this report.

1 recommendation in relation to the details of the member of staff who withdraws monies from the bank on behalf of patients is recorded was not assessed as this was no longer applicable to the ward.

4.4 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 July 2011. 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 in relation to:

- All Serious Adverse Incidents are reported in accordance with the Health and Social care Board Regional Procedure.
- WHSCT staff fire training included the demonstration of fire extinguisher use.
- Posters were displayed at ward entry points in Lakeview and informed visitors that all ignition materials for patient use must be handed in to the nurse in charge
- The admission checklist for Lakeview Hospital included a section for ignition materials/cigarettes and outlined the adherence necessary with regard to these items.
- Protocol within Lakeview was devised regarding the supply to and possession of ignition materials and cigarettes on return from home leave of special outings.

However, the following recommendations had not been fully implemented and will be restated in the Quality Improvement Plan (QIP) accompanying this report.

- The WHSCT's hospital visiting policy, section 4, Visitors' guidance did not include reference outlining the adherence necessary with regard to the supply/possession of cigarettes and ignition materials to inpatients
- The aspect and risk of inpatients' possession and access to ignition materials was not included in all staff induction programmes

The recommendation in relation to the Personal search policy for inpatients to be reviewed and updated was not assessed during the inspection; this recommendation will be assessed during the next inspection.

Details of the above findings are included in Appendix 1.

5.0 Inspection Summary

Since the last inspection it was good to note that all staff had attended training in relation to Management of Actual and Potential Aggression (MAPA), Managing Complaints, Safeguarding and Protection of Vulnerable Adults and Children, Restrictive Practices, Human Rights and Deprivation of Liberty and Capacity Awareness Training.

There was evidence of advocacy involvement on the ward.

Resettlement meetings were occurring on a monthly basis and were attended by all appropriate persons.

Patient forum meetings had commenced and occurred regularly on the ward.

It was also good to note that following incident review meetings held on the ward, which highlighted an increase in the number of vulnerable adult referrals

occurring at the weekends, a decision was made to increase the staffing levels at the weekends.

Inspectors were pleased to note that the ward had made progress toward achieving compliance with the recommendations made following the financial inspection in January 2014.

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.

Inspectors noted that policies, procedures and the Department of Health Guidance in relation to Capacity to Consent and Best Interests were available to staff on the ward. Inspectors were pleased to note that a family member stated they had been invited to all their relatives multi-disciplinary and resettlement meetings and had been consulted in any decision making about their relatives care. The relative had stated that their wishes were always considered. It was good to note that a patient stated they had attended their multi-disciplinary and resettlement meetings and had an advocate to support them.

Inspectors found it was not recorded in the care documentation if patients had capacity, or what their level of understanding was. Care plans did not detail; how staff would know if a patient was consenting or not, what action staff take to ensure patients understand their care and treatment, or what staff do when a patient does not consent. There was no evidence in the care documentation reviewed that staff have sought consent before supporting or providing any care to the patient.

It was good to note that staff working on the ward were familiar with the patients' needs and informed inspectors how they would know if a patient was or was not consenting. Staff also informed inspectors of the steps they would take to establish if a patient was consenting, by giving patients information and sufficient time to understand their care plans. The four staff interviewed also informed inspectors of the action they would take if a patient was not consenting, for example stop the activity and return another time.

Patients were invited and do attend their multi-disciplinary meetings when appropriate. However discussions with patients before and after the multi-disciplinary meetings were not consistently recorded in the minutes. Reasons for patient's non-attendance or where outcomes were not discussed was not recorded. There was also inconsistent inpatient signatures throughout the care documentation reviewed.

There was no evidence in the multi-disciplinary meeting minutes or care documentation that patients had been given time to understand the implications of their care and treatment.

Consideration to Human Rights Article 8 respect for private and family life and Article 14 right to be free from discrimination was not documented in the care documentation reviewed.

A family member spoken to on the days of the inspection informed inspectors that they had been involved in assessments in relation to the care and treatment of their relative.

Care documentation reviewed by inspectors on the day of the inspection was found to be incomplete. Patients' needs were not assessed comprehensively, areas on assessments were left blank or there was limited information recorded. Inspectors noted that there was a variety of assessments used for each patient. Of the four sets of care documents reviewed, inspectors found that one patient had a Roper, Logan and Tierney assessment completed, two patients had an Orem assessment completed in addition to a Roper Logan and Tierney and one patient had a generic type nursing assessment which did not include an assessment the patients complex needs. Nursing staff working on the ward on the days of the inspection could not provide a rationale for their use of one nursing assessment over another. Assessments lacked detail about the patients' needs, activities of living were not completed, patients' choices and their likes and dislikes were not consistently documented. Where patients had not signed their assessments a reason for this was not recorded

On the days of the inspection, inspectors reviewed care documentation relating to four of the eight patients on the ward. Inspectors noted that all of the patients were presenting with behaviours that challenge resulting in the use of physical interventions. There was a care plan in place for each patient reviewed to guide this practice. However, there were no comprehensive assessments completed in relation to patients' behaviours and inspectors were concerned to note that there was no evidence of care interventions to guide staff on ways to positively address the behavioural presentation. Inspectors were informed that patient's behaviour was not being assessed and recorded in patient care documentation using recognised assessment tools, however information relating to patients presentation was captured on datix forms following incidents on the ward.

Inspectors were concerned with the completion of risk screening and assessment to inform patient care and treatment. A comprehensive risk screening tool had not been completed for one patient out of the four reviewed, contrary to regional guidance. Where a comprehensive risk screening tool had been completed, these had not been completed fully by a multi-disciplinary team. There was a lack of clarity in the records to indicate if the patient did or did not require a comprehensive risk assessment. Comprehensive risk assessments and management plans that had been completed were not available or completed fully in accordance with published guidance. Patients on Brooke Lodge present with behaviours that challenge and there is a risk of patients assaulting other patients, yet there was no risk management plans available in the patients care documentation about how this could be managed. It was not evident who was responsible for monitoring of the comprehensive risk assessment. Two comprehensive risk

assessments had not been reviewed.

In the four sets of care documentation reviewed, assessments in relation to how patient's communicates lacked detail. For example it was documented that a patient communicated non -verbally, however there was no explanation as to how this patient made their needs known non verbally. It was good to note that staff were familiar with the communication needs of the patients, and described how they adapted their own communication to meet the patient's needs. However, this vital information had not been included in the patients' assessments and care plans to guide care and practice and ensure consistency across all staff working with patients on the ward.

On the days of the inspection, inspectors observed staff engaging patients in activities, such as walks, supporting patients to attend "Berryburn" day centre and one patient was enjoying a foot spa. Patients had the opportunity to access the day care facility situated within the hospital site where they could avail of art, white sensory room, dark sensory room, soft play area, multi-sensory room, therapy/beauty room, and a Jacuzzi. It was good to note that patients could access the "Berryburn" day care facility during the evenings and weekends with staff support. Patients also had access to several outdoor spaces. Other day time activities within the hospital site included Sow and Grow garden centre and a day centre outside the hospital site.

Inspectors were informed by the deputy ward manager that patient attendance at day care varied and was according to the patients assessed needs. However, there were no assessments or information in relation to patients choices, likes and dislikes in the care documentation or a rationale recorded for this decision. There was no evidence of individualised therapeutic and recreational programmes however ward / group therapeutic and recreational activity programmes were not available on the ward. Staff were aware of patients' likes and dislikes in relation to social and therapeutic activities.

Information in relation on how to make a complaint was available in several formats, such as the use of words, symbols and pictures. Information in relation to accessing advocacy services, how the ward uses information about the patient, the Mental Health Order and how patients can comment on their care and experience of Brooke Lodge was also available in easy read format on the ward. Patients had access to advocacy and described the nature of support the advocate provided. The ward information booklet was in easy read format. The ward booklet did not include details of any outside agencies the patient may contact when concerned about their care and treatment e.g. RQIA, Ombudsman, GMC or NMC.

Staff knew how to access and effectively use advocacy services. The independent advocate attends patients' resettlement meetings.
Patient forum meetings are now convened 1 – 2 monthly.

There was no reference to Article 5 rights to liberty and security of the person, Article 8 rights to respect for private and family life, Article 14 rights to be free from discrimination recorded in the patients care documentation.

None of the patients on the ward were subject to detention for assessment or treatment under the Mental Health (Northern Ireland) Order 1986 on the days of the inspection. Entry and exit to the ward was controlled by staff. This deprivation of liberty and the potential implications of this practice on patients Human Rights was not recorded in the care documentation reviewed in line with DHSSPS Interim Guidance - Deprivation of Liberty (2010). The rationale for the use of this level of restriction in terms of necessity and proportionality was not supported by comprehensive risk assessment and care planning.

Inspectors noted the WHSCT policy on the use of restrictive interventions with adult service users and risk assessment (appendix B) had been completed for each patient.

There was no evidence that any restrictions including the locked door had been discussed with the patients or their representatives.

Inspectors were concerned to note that physical interventions are used on the ward. Staff working on the ward were unable to provide information relating to the frequency of use of this type of intervention. RQIA inspectors were informed that this information was captured in individual care records but weekly or monthly figures for the incidence of this restrictive intervention on the ward were not collated. Care documentation reviewed by inspectors on the days of the inspection evidenced that three out of the four patients had been subject to physical interventions in the three days preceding the commencement of the inspection. This suggests that this intervention is used on the ward on a regular basis.

On the days of the inspection the discharge of four patients was described as delayed. One family member reported they had been fully involved in their relatives discharge resettlement planning. The patient, their family member and visiting social worker all expressed their concern regarding a lack of appropriate community placements. Inspectors noted resettlement meetings occurred on a monthly basis and were attended by patients, their representative if appropriate, their community key worker, the independent advocate and ward staff. There was evidence in the care documentation of joint working with outside agencies that offered a potential placement for patients assessed for resettlement. However there was no evidence in the care documentation reviewed of any care interventions and support to prepare patients for their move to community.

Due to the serious nature of these matters, concerns were drawn to the attention of the Western Health & Social Care Trust's Director of Mental Health and Disability, in line with RQIA's Escalation policy. A meeting with senior Trust representatives was held on 21 October 2014 to discuss the actions to be taken by the WHSCT to address these concerns. Senior Trust representatives gave assurances to RQIA that the areas of concern highlighted within this report would be addressed immediately.

Details of the above findings are included in Appendix 2.

On this occasion Brooke Lodge has achieved an overall compliance level of not 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	**One**
Ward Staff	**Four**
Relatives	**One**
Other Ward Professionals	**Two**
Advocates	**None**

Patients

Inspectors spoke with one patient during the inspection. The patient informed inspectors that the staff were good. The patient indicated they had been informed of the vulnerable adult process and had been kept up to date in relation to a referral. The patient was aware of how to make a complaint and had a good relationship with their advocate. The patient expressed their frustration at the length of time it was taking to find them an appropriate community placement. The patient stated they enjoyed attending day time activities and social events in the evening.

Relatives/Carers

Inspectors spoke with one family member during the inspection. The family member stated they were happy with the care their relative received. The relative stated;

"the staff have a challenging job and it's not easy but they are good at their job and they have no concerns"

The relative stated they had been kept fully informed of their relatives care and treatment plans and had been contacted if there were any incidents or accidents involving their relative.

Ward Staff

Inspectors spoke with nursing staff on the ward. All staff were familiar with the patients' needs on the ward. Staff felt supported by the deputy and ward manager. Staff indicated they enjoyed working with the patient population and acknowledged the challenges experienced at times due to the complex needs of the patients.

Other Ward Professionals

Inspectors spoke with a visiting social worker. The social worker expressed their concerns in limited resources and appropriate facilities available in the community. The social worker stated the staff on Brooke lodge appropriately refer any safeguarding vulnerable adult issues and any incidents and accidents. The social worker confirmed resettlement meetings are convened on a monthly basis. The social worker indicated they had no concerns in relation to the care of the patients on Brooke lodge.

Inspectors spoke with the designated officer for Lakeview hospital. The designated officer stated there is a large volume of Safeguarding Vulnerable Adult referrals completed by staff on Brooke Lodge. The majority of these were as result of patient on patient assault. Protection plans were completed.

Advocates

The inspection was unannounced. There were no advocates available on the days of the inspection.

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

Questionnaires issued to	Number issued	Number returned
Ward Staff	25	2
Other Ward Professionals	25	0
Relatives/carers	8	1

Ward Staff

There were two questionnaires returned by nursing staff. Both staff stated they had received training in the following; Human Rights, Deprivation of liberty(DOLS) – interim guidance (2010). One staff member stated they had not received training in capacity to consent. Both staff indicated they were aware of restrictive practices on the ward and had received training in relation to these practices. One staff stated they had not received any training in relation to meeting the needs of patients who require support with communication. Both staff indicated that patients' communication needs were recorded in their assessment and care plan and they were aware of alternative means to communication. Both staff stated the ward had information to meet individual needs in relation to; The Mental Health Order, detention processes, making a complaint and accessing advocacy services. Both staff stated patients' have access to therapeutic and recreational activities.

Other Ward Professionals

There were no questionnaires returned from other ward professionals

Relatives/carers

There was one questionnaire returned by a family member. The family member rated the care on the ward as good. The family member stated their relative had been offered the opportunity to be involved in their care and treatment on the ward, had been involved in the decisions and had an individual assessment completed in relation to therapeutic and recreational activity. The family member was aware of restrictive practices on the ward. The family member stated;

"I do wish the staff would encourage patients to go into the garden when we have a sunny day, and take them for short walks"

7.0 Additional matters examined/additional concerns noted

Complaints

There were two complaints made by relatives between 1 April 2013 and 31 March 2014. These were confirmed during the inspection and were in relation to care practice. The outcomes of both complaints were fully satisfied.

Additional concerns

Inspectors were concerned that a patient had been admitted two days previous to the inspection with suicidal ideation. The patient was provided with a profiling bed. Inspectors noted that staff were aware of the Estates and Facilities Alert (DOH) June 2010 "Self harm associated with profiling beds". Staff had completed a generic care plan in relation to the use of profiling beds in mental health and learning disability services, but did not complete a separate risk assessment or identified any control measures. A recommendation has been made in relation to this.

Inspectors were informed that future incidents where patients present with behaviours that challenge that result in the use of physical intervention will only be documented on the trust electronic incident recording system (DATIX) with reference to the DATIX number made in the patients daily progress notes and recognized tools used to assess behavior will no longer be used on the ward. Inspectors were concerned that this recording system is not a recognised evidenced based behaviour assessment tool, as it would only detail the actual incident and the intervention required at the time and not the antecedent to the behaviour. In addition this could also mean that practice on the ward would be reactive rather than proactive as analysis of incidents would only occur post incident. Inspectors were also concerned that not all staff on the ward had access to previous incidents on the DATIX system.

The head of service shared future proposed changes to the current procedures in relation to the trust response to and management of incidents. Inspectors were concerned that this proposal may not be in keeping with regional guidance in relation to Safeguarding of Vulnerable Adults, and may not offer patients the level of protection necessary. A recommendation has been made in relation 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.

Follow-up on recommendations made following the unannounced inspection 12 February 2014

No.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	It is recommended that all staff receive training in dealing with complaints.	Inspectors reviewed training records for staff working on the ward. 15 out of 16 staff working on the ward had received up to date training in dealing with complaints. A new staff member was scheduled to attend training on 10 September 2014 however inspectors were informed this training had been cancelled by the trust. Training has been rescheduled for this staff member in October 2014	**Fully met**
2	It is recommended that all staff receive training in challenging behaviour, to include the use of restrictive practices and physical interventions.	Inspectors reviewed training records for staff working on the ward. All 16 staff working on the ward had received training in Management of Actual and Potential Aggression (MAPA), restrictive practices, Human Rights and Deprivation of Liberty (DOLS) interim guidance (2010)	**Fully met**
3	It is recommended that all staff receive up to date training in the protection of vulnerable adults.	Inspectors reviewed training records for staff working on the ward. All 16 staff working on the ward had received up to date training in protection of vulnerable adults.	**Fully met**
4	It is recommended that the acting ward manager and all staff on the ward receive regular supervision and appraisal.	Inspectors reviewed the supervision and appraisal records for staff working on the ward. All 16 staff working on the ward, including the two band 6 had received up to date supervision and appraisal.	**Fully met**
5	It is recommended that regular staff meetings are held and that all staff have the opportunity to attend these.	Inspectors reviewed records and minutes in relation to staff meetings convened on 17 April 2014 and 16 July 2014. Minutes of the staff meetings contained an agenda and recorded outcomes. Minutes from the staff meetings were stored in the nursing office and could be accessed by all staff.	**Fully met**
6	It is recommended that a staff	Inspectors reviewed the training records for staff working on the ward.	**Fully met**

	training and development plan is developed for the ward and that all training needs are identified and actioned.	Inspectors noted all staff had attended mandatory training and other training appropriate to the ward as follows Restrictive Practice, Human Rights, Deprivation of Liberty. All staff had attended training on Capacity Awareness. Inspectors were informed by a nursing assistant that they were in the process of completing their level 3 NCQ qualification supported by the trust.	
7	It is recommended that all staff receive training and information in relation to the application of the Trust's safeguarding vulnerable adult procedures to their area of work.	Inspectors reviewed the training records for staff working on the ward. All 16 staff working on the ward had undertaken up to date training and information in relation to the application of the Trust Safeguarding Vulnerable Adult procedures. Inspectors interviewed two staff on the ward. Both staff knew what constituted a vulnerable adult referral, how to raise a concern, and what appropriate measures were required. Inspectors spoke to the Safeguarding Vulnerable Designated Officer and a visiting social worker. Both staff stated ward staff were completing appropriate vulnerable referrals.	**Fully met**
8	It is recommended that staff undertake training in child protection.	Inspectors reviewed the ward training records for staff working on the ward. All 16 staff working on the ward had undertaken up to date training in child protection.	**Fully met**
9	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.	Inspectors reviewed care documentation in relation to four patients. Inspectors found that; • Patient signatures were inconsistent throughout three sets of care documentation. • Signatures were not evident on one set of care documentation. • Where patients had not signed their care documentation, the reason for this as not recorded This recommendation will be restated for a second time.	**Not met**

		Inspectors noted it stated in the one set of care documentation that the patient “was unable to sign due to their learning disability”. A new recommendation will be made in relation this.	
10	It is recommended that the Nurse in Charge ensures that the ward’s review of patient file structure is completed in accordance with the Trust’s timetable.	Inspectors reviewed care documentation in relation to four patients. Inspectors noted that the file structure had been reviewed. Files were in sequential order, as follows, assessments, risk assessments, care plans, nursing progress notes and other relevant information and correspondence. However inspectors found that the files were difficult to navigate and follow, and the content of the four sets of care documentation was different eg different models of assessment had been used. Inspectors were informed by the ward manager and head of service that a new file structure would be implemented by December 2014. Inspectors reviewed the new file structure template, and were informed this template will be the only care documentation used in Lakeview. This recommendation will restated for a second time.	**Not met**

Appendix 1

Follow-up on recommendations made following the patient experience interview inspection on 8 April 2014

No.	Reference.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	8.3 k	It is recommended that the ward sister ensures that all patients have access to the complaints procedure in a format appropriate to their individual communication needs**.**	Inspectors noted that a variety of easy read versions of the Trust complaints procedure was available for patients on the ward. Patient forum meetings had commenced on the ward. Inspectors reviewed the minutes of one of the meetings; and noted issues raised by patients had been addressed appropriately.	**Fully met**
2	8.3 e	It is recommended that the ward sister ensures that all patients are made aware of the wards' do's and don'ts.	Inspectors reviewed an easy read booklet which detailed the do and don'ts of the ward, the ward routine, and the available professionals.	**Fully met**
3	5.3.3 a , b	It is recommended that the ward sister ensures that all patients are aware of their diagnosis and treatment plan.	Inspectors reviewed the minutes of the weekly ward round meetings for four patients. Inspectors were informed by the deputy ward manager that patients are encouraged to attend their weekly ward round. Inspectors reviewed weekly ward round minutes in relation to four of the eight patients on the ward. There was evidence of patients signatures to record attendance or non-attendance on the weekly ward round minutes in two of the four sets of care documentation reviewed. A rationale was recorded in both sets of care documents why the patients had not attended and evidenced that the outcomes from the ward round were discussed with the patients. However this was not evident	**Partially met**

			in the other two sets of care documents reviewed. This recommendation will be restated for a second time. In four of the eight sets of care documentation reviewed there was no evidence that the patients' diagnosis and treatment plans had been discussed in a format suitable to meet their individual communication needs. A new recommendation will be made in relation to this	
4	8.3 h	It is recommended that the ward sister ensures that all documentation in relation to physical interventions is completed in line with Trust policy and procedure.	Inspectors reviewed documentation in relation to four of the eight patients on the ward in relation to the use of physical interventions. Each patient had a WHSCT Trust Risk Assessment / Restrictive Interventions form completed. Patients had individualised physical intervention assessment completed detailing the level of physical intervention to be used. All incidents that involved the use of physical intervention were recorded in the patients care documentation and on the Trust DATIX system. However in keeping with the Trust Policy appendix B Application of Restrictive Interventions had not been completed every time a restrictive intervention had been used. This recommendation will be restated for a second time	**Partially met**
5	5.3.1 f	It is recommended that the Trust ensures that formal governance arrangements are in place to monitor the use of physical interventions on the ward.	Staff working on the ward were unable to provide information relating to the frequency of use of this type of intervention. Inspectors were informed that this information was captured in individual care records but weekly or monthly figures for the incidence of this restrictive intervention on the ward were not collated. This recommendation will be restated for a second time	**Not met**

6	5.3.1 a	It is recommended that the ward sister ensures that all patients subject to physical interventions are informed of the reason and this is documented in the patients' care documentation.	Inspectors reviewed documentation in relation to two patients who had been subjected to physical interventions. There was no evidence in the patients care documentation that the reason for the physical intervention had been explained or a rationale recorded if this was not appropriate. This is not in keeping WHSCT Policy for the Use Of Restrictive Interventions with Adult Service Users. This recommendation will restated for second time	**Not met**
7	5.3.3 f	It is recommended that the trust develops a physical intervention monitoring form that is in keeping with Department of Health regional guidelines on the HUMAN RIGHTS WORKING GROUP ON RESTRAINT AND SECLUSION Guidance on Restraint and Seclusion in Health and Personal Social Services AUGUST 2005	Inspectors reviewed physical intervention monitoring forms in relation to three incidents where physical intervention had been used. The form was in keeping with the Department of Health regional guidelines on the HUMAN RIGHTS WORKING GROUP ON RESTRAINT AND SECLUSION Guidance on Restraint and Seclusion in Health and Personal Social Services AUGUST 2005	**Fully met**

Appendix 1

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

No.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	It is recommended that the ward manager ensures that a record is of the staff member who obtains the key to safe is maintained, including the reason for access.	Inspectors reviewed the arrangements in place for the management of patient finances. Inspectors noted a record was kept daily. Each financial transaction was signed in and out. The reason for access was signed and documented	**Fully met**
2	It is recommended that the ward manager ensures that individual transactions are fully recorded for each patient, to verify the withdrawals, expenditure and change returned to the ward	Inspectors noted that each patient had an individualised recording book. Individual transactions were recorded and included withdrawals, expenditure and change returned to the ward. Receipts for expenditure were retained and signed by two staff or one staff and patient where possible.	**Fully met**
3	It is recommended that the ward manager ensures that a daily check of the safe includes a check of the amount of money held in the safe against the cash record on the day.	Inspectors noted a daily check of the safe was completed and included a check of the amount of money held in the safe against the cash record on the day.	**Fully met**
4	It is recommended that the ward manager ensures the cash ledger records are held separately and securely from the money wallet.	Inspectors noted cash ledger records were held separately from the patients money wallets	**Fully met**
5	It is recommended that the ward manager ensures that all items brought into the ward on admission are listed appropriately, the area of their storage or transfer recorded, and appropriate receipting undertaken, particularly when relatives remove items from the ward.	Inspectors noted a duplicate book was maintained to record all patients' items brought into the ward on admission. The area of storage or transfer was recorded. A copy of the record was maintained in the patients' documentation.	**Fully met**

6	It is recommended that the ward manager ensures that regular statements are received from the cash office to facilitate verification of transactions and expenditure.	Inspectors were informed by the deputy ward manager that regular statements are not received from the cash office to facilitate verification of transactions and expenditure. This recommendation will be restated for a second time	**Not met**
7	It is recommended that the Trust develops and implements a policy and procedure in relation to operating individual patient saving accounts.	Inspectors were informed by the deputy ward manager that a draft policy had been developed in relation to operating individual patient saving accounts. The draft policy was not available on the ward This recommendation will be restated for a second time	**Not met**
8	It is recommended that the ward manager ensures that transparent records are maintained in relation to the use of patients' monies, including receipts for purchases and records of reconciliation of records, cash and receipts.	Inspectors noted patients had individual cash transaction records maintained. This detailed the use of patient's monies. A copy of receipts for any purchases is retained on the ward. All transactions were signed by either two staff or one staff and the patient.	**Fully met**
9	It is recommended that the ward manager ensures details of the member of staff who withdraws monies from the bank on behalf of patients is recorded.	The deputy ward manager informed inspectors that this recommendation was made in relation to a previous patient. This patient is no longer on the ward. The deputy ward manager stated this practice is currently not happening on the ward.	**Not assessed as no longer applicable**
10	It is recommended that the ward manager ensures that all receipts are noted with the individual patient's name and held with the patient's cash records.	Inspectors noted all receipts were retained in the patients individual cash records. The patients name was recorded on each receipt	**Fully met**
11	It is recommended that the ward manager ensures that updated training in the management of patients' finances is prioritised for all staff.	The inspectors were informed that training in the management of patients finances is not available to staff This recommendation will restated for a second time	**Not 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 07-11	It is recommended that the Trust ensure that all Serious Adverse Incidents are reported in accordance with the Health and Social care Board Regional Procedure.	Inspectors were informed by the deputy ward manager and hospital manager of the procedure to follow following a Serious Adverse Incident. The deputy ward manager stated all Serious Adverse Incidents are reported in accordance with the Health and Social Care Board Procedure for the Reporting and Follow up of Serious Adverse Incidents. This recommendation will be removed and not included in the Quality Improvement Plan.	**Not assessed**
2	SAI 07-11	When reviewing the WHSCT's hospital visiting policy, section 4, Visitors' guidance to include reference outlining the adherence necessary with regard to the supply/possession of cigarettes and ignition materials to inpatients	Inspectors reviewed WHSCT visiting policy. The policy had been written in August 2008 and had not been reviewed. The policy did not include reference outlining the adherence necessary with regard to the supply/possession of cigarettes and ignition materials to inpatients. This recommendation will be restated for a second time	**Not met**
3	SAI 07-11	WHSCT staff fire training to include the demonstration of fire extinguisher use.	The ward manager informed the inspectors that fire training does include guidance on how to use a fire extinguisher. Inspectors spoke with two staff in relation to their fire training and were informed fire training	**Fully met**

			includes guidance on the use of a fire extinguisher	
3	SAI 07-11	The aspect and risk of inpatients' possession and access to ignition materials to be included in all staff induction programmes.	Inspectors reviewed the staff induction programme and noted the aspect and risk of inpatients possession and access to ignition materials was not included. This recommendation will be restated for a second time	**Not met**
4	SAI 07-11	Posters to be displayed at ward entry points in Lakeview informing visitors that all ignition materials for patient use must be handed in to the nurse in charge	Inspectors noted that posters informing visitors that ignition materials for patient use must be handed in to the nurse in charge. However inspectors were concerned that this restriction has the potential to be viewed as a blanket restriction. A new recommendation has been made in relation to this.	**Fully met**
5	SAI 07-11	Admission checklist for Lakeview Hospital to include section for ignition materials/cigarettes and if applicable outline the adherence necessary with regard to these items.	Inspectors reviewed patients admission checklists and noted this did include a section for ignition materials / cigarettes and the necessary adherence with regard items	**Fully met**
6	SAI 07-11	Protocol within Lakeview to be devised regarding the supply to and possession of ignition materials and cigarettes on return from home leave of special outings.	Inspectors noted that a protocol "For the Management of Ignition Materials and Cigarettes within Lakeview Hospital" had been devised in September 2011	**Fully met**
7	SAI 07-11	Personal searches policy for inpatients to be reviewed and updated	Inspectors were informed by the ward manager and head of service that the policy in relation to personal searches had been reviewed in line with the new regional policy.	**Not assessed**

			This recommendation was not assessed during the inspection. This recommendation will be assessed in the next inspection	

The Regulation and Quality Improvement Authority

Quality Improvement Plan

Unannounced Inspection

Brooke Lodge, Lakeview Hospital

13 & 14 October 2014

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

The specific actions set out in the Quality Improvement Plan were discussed with Ward manager, Deputy Ward manager and the head of service on the day of the inspection visit.

Any matters that require completion within 28 days of the inspection visit have also been set out in separate correspondence to the professional lead nurse.

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	31 December 2014	We will ensure appropriate entries are made in all relevant documention to denote either a patients unwillingness or inability to sign
2	5.3.1 (a)	It is recommended that the Nurse in Charge ensures that the ward's review of patient file structure is completed in accordance with the Trust's timetable	2	31 December 2014	A complete revision of nursing documentation is underway with completion anticipated before end of December 2014.
3	5.3 (a) & (b)	It is recommended that the ward sister ensures that all patients are aware of their diagnosis and treatment plan and reason recorded when this is not appropriate	2	31 December 2014	Staff will ensure records are made that patients have had their reason for admission, medical diagnosis and related treatment plans advised. Use of easy read documentation is presently being implemented to supplement information for patients.
4	8.3 (h)	It is recommended that the ward sister ensures that all documentation in relation to physical interventions is completed in line with Trust policy and procedure	2	31 December 2014	Documentation is being being reviewed to ensure a consistent approach in line with Trust policy.

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
5	5.3.1 (f)	It is recommended that the Trust ensures that formal governance arrangements are in place to monitor the use of physical interventions on the ward.	2	31 December 2014	Use of physical interventions are audited as part of monthly (multi disciplinary) Incident Review Meetings.
6	5.3.1 (a)	It is recommended that the ward sister ensures that all patients subject to physical interventions are informed of the reason and this is documented in the patients' care documentation.	2	Immediate and ongoing	All patients who require physical interventions have this prescribed within their careplan. We will ensure where any use is required to be made, the discussion held with the client will be documented in the patients daily notes, and any comments or feedback from the patients included
7	5.3.1 (f)	It is recommended that the ward manager ensures that regular statements are received from the cash office to facilitate verification of transactions and expenditure.	2	28 February 2015	Monthly requests will continue to be made to the cash office to obtain statements
8	5.3.1 (f)	It is recommended that the Trust develops and implements a policy and procedure in relation to operating individual patient saving accounts.	2	28 February 2015	This will be reviewed.

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
9	4.3 (m)	It is recommended that the ward manager ensures that updated training in the management of patients' finances is prioritised for all staff.	2	28 February 2015	All staff training on the management of patients finances will be updated by 28th February 2015
10	5.3.2	It is recommended that the ward manager ensures that the aspect and risk of inpatients' possession and access to ignition materials to be included in all staff induction programmes	2	28 February 2015	This was in place but an incorrect form presented at inspection. All old forms have been removed, this will be included for new staff induction.
11	5.3.2	It is recommended that personal searches policy for inpatients is reviewed and updated	1	28 February 2015	The hospital operates in line with the Regional Search Policy for Mental Health and Learning Disability Inpatient Settings.
12	5.3.3 (b)	It is recommended that the ward manager ensures that where patients are unable to sign their care documentation that the reason for this is documented in relation to the patients' capacity to understand the information.	1	31 December 2014	Care plans are being reviewed to ensure records regarding the patients' ability , lack of ability, or willingness are appropriately documented. This shall be completed by 31st December 2014.

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
13	6.3.2 (b)	It is recommended that the ward manager ensures that there is documented evidence to show that all attempts and reasonable adjustments have been made to ensure patients are informed of their diagnosis and care treatment plans in a format suitable to their individual communication needs and are given time to understand the implication of their care and treatment. A clear rationale should be provided when this is not appropriate.	1	Immediate and ongoing	A range of easy read information have been implemented (where required) to support patients awareness and understanding of their diagnosis and treatment plan. Where a patient declines this information this shall be recorded.
14	5.3.1 (f)	It is recommended that the ward manager ensures staff assess patients consent to participate in daily care activities and that this is recorded.	1	Immediate and ongoing	Records of a patient's consent to participate or not to participate will be recorded within patients' records forthwith.
15	5.3.3 (b)	It is recommended that the ward manager ensures patient	1	Immediate and	This has beem implemented.

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
		attendance or non-attendance at the multi-disciplinary meetings is consistently documented. This should include a rationale when patients do not attend.		ongoing	
16	7.3 (c)	It is recommended that the ward manager ensures all staff working on the ward consider the potential impact of care and treatment on the patients Human Rights and that this is clearly documented in the patients care documents.	1	31 December 2014	A full review of all patients' care plans has been completed, which includes direct consideration of any Human Rights implications. Appropriate records are now in place with any outstanding due for completion in full by 31st December 2014.
17	5.3.1 (a)	It is recommended the ward manager ensures that patients assessments are undertaken using appropriate recognised and evidenced based tools that addresses the complex needs of this population.	1	31 December 2014	A revised assessment tool, based on Roper Logan and Thierney has been implemented, incorporating aspects of Orem as required. All patients are in the process of being reassessed against the new assessment tool and a revised plan of care developed. Any outstanding shall be completed before end of December 2014.

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
18	5.3.1 (a)	It is recommended that the ward manager ensures that assessments are completed fully, reflect patient's needs and include patient choices and likes and dislikes.	1	31 December 2014	Almost all care plans have been rewritten with any outstanding due for completion for end December 2014. This addresses old documentation which had been incompletely written. Patients' likes and dislikes are now clearly noted.
19	5.3.1 (a)	It is recommended that the ward manager ensures that patients and / or their representatives have the opportunity to contribute to their assessments and care plans and a rationale recorded when this is not appropriate.	1	31 December 2014	All patients are encouraged to participate in their assessment and care plan, where this is not attainable a clear record shall be made. Patient representatives are requested to participate and agree the care plans . Statutory professionals are also requested to participate in any risk assessment alongside the patient or patient representative.
20	5.3.1 (a)	It is recommended that the ward manager ensures that patients who present with behaviours that challenge have a multi-disciplinary assessment completed using recognised appropriate evidenced based assessment tools.	1	31 December 2014	All patients that present with behaviours that challenge have a multi-disciplinary assessment completed and on file. Old copies which were incomplete have been revisited and updated using regionally recognised assessment tools

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
21	5.3.1 (a)	It is recommended that the ward manger ensures that patients who have been assessed as presenting with behaviours that challenge have a plan in place that guides staff to proactively support and positively address presenting behaviours.	1	28 February 2015	Proactive and reactive strategies are prescribed for every patient who has behaviours known to challenge. Staff also receive training on non aversive interventions and an aide memoire is available on the ward.
22	5.3.1 (a)	It is recommended that the ward manager ensures that staff completing comprehensive risk screening tools and comprehensive risk assessments and management plans, do so in accordance with Promoting Quality Care Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services May 2010.	1	31 December 2014	Agreed and implemented.
23	5.3.1 (a)	It is recommended that the ward manager ensures that all patients have an assessment of their communication needs and when identified that a patients has a	1	31 December 2014	All patients will have an assessment of their communication needs completed by end of December 2014. Feedback and involvement of staff who know the patients well is encouraged.

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
		particular communication need that a care plan is completed to guide staff on how to best communicate with the patient. All staff working on the ward who are familiar with the patients should contribute to this.			
24	5.3.1 (a)	It is recommended that the ward manager ensures that all patients have an assessment of their therapeutic and social activity needs and an individualised therapeutic and social activity plan developed.	1	31 December 2014	Implemented.
25	5.3.3	It is recommended the ward manager develops a ward / group therapeutic and recreational activity programme in conjunction with patients and / or their representatives.	1	28 February 2015	This is under development at present and will be operational in advance of 28th February 2015.

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
26	5.3.1 (a)	It is recommended that the ward manager ensures that patients who have been assessed as requiring a structured day have been provided with structured timetable and a plan in place to guide staff to support the patient.	1	28 February 2015	Implemented.
27	8.3 (k)	It is recommended that the ward manager ensures that the ward information booklet includes the details of the all outside agencies the patient may contact when concerned about their care and treatment for example RQIA, Ombudsman, Patient Client Council.	1	28 February 2015	Details inserted, to compliment the patients complaints leaflet.
28	8.3 (k)	It is recommended the ward manager ensures that patients have been informed of their rights to make a complaint, access independent advocacy services and accept or refuse care treatment, and that this is clearly	1	Immediate and ongoing	Completed.

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
		documented in the patients care records.			
29	5.3.1 (a)	It is recommended that the ward manager ensures patients who require restrictive interventions have an individual risk assessment and management plan in place that reflects the patients' complex needs.	1	31 December 2014	A new multi disciplinary risk assessment has been introduced, incorporating capacity and human rights considerations with respect to restrictive practice. Any outstanding files will be revised and completed by 31st December 2014.
30	5.3.2	It is recommended that the ward manager ensures that staff adhere to the WHSCT Policy on the use of restrictive interventions with adult service users and any documentation completed when a restrictive intervention has been used is completed in accordance of this policy.	1	Immediate and ongoing	Agreed. Current policy is being reviewed for applicability in terms of capacity and Human Rights.
31	5.3.1 (a)	It is recommended the Trust reviews all blanket restrictions on the ward including the locked exit door from the ward and the	1	31 December 2014	Completed. Trust reviewed Lakeview Locked Door Protocol and Access to Ignition Materials on the ward. Individual risk assessments and management plans are in place per patients with

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
		removal of ignition materials, and provides a clear rationale for these practices which should include individual patient assessments in line with DHSSPS Deprivation of Liberty Interim Guidance October 2010.			appropriate measures in place to reduce impact through provision of a ward swipe. ie. Human Right impacts are considered and documented within the plans, with best interest decisions recorded. All risk plans are signed off by the relevant members of the multi disciplinary team, patient and patients representative as appropriate.
32	6.3.2 (b)	It is recommended that the ward manager ensures that patients and / or their representatives are fully informed of all restrictive interventions used on the ward and the rationale for their use and that this is recorded in the patients care documentation.	1	31 December 2014	New care and risk plans have been written which focus clearly on restrictive interventions, including capacity, human rights and any potential for deprivation of liberties, with a clear explanation and agreement of the relevant multi disciplinary team members recorded. Any outstanding plans will be completed by 31st December 2014.
33	5.3.3	It is recommended that the ward manager ensures that each patient has a discharge pathway documented in their care plan. This should include definitive action plans, responsible person for their delivery and timescales.	1	31 December 2014	Care plans are being reconsidered and rewritten, with a clear discharge pathways included. Any outstanding plans will be completed by 31st December 2014.

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
34	6.3.1 (a)	It is recommended that the ward manager ensures that each patient who is admitted for care and treatment has a clear rationale recorded when the patients discharge has been delayed.	1	Immediate and ongoing	This has been addressed .
35	5.2.1 (a)	It is recommended that the ward manager ensures that care and treatment plans completed for patients who are readmitted are re-evaluated and reviewed on every admission and include a review of the reason why patients are readmitted. Patient's care plans should detail what therapeutic interventions have been considered during the admission to look at reducing the risk of future readmissions.	1	Immediate and ongoing	This will be implemented for any future readmission
36	5.3.1 (a)	It is recommended that the ward manager ensures there is	1	Immediate and	This has been addressed with improved communication received and increased attendance

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
		collaborative working between hospital and community service to ensure that information in care plans that are used in the community are shared with the hospital staff.		ongoing	at ward rounds
37	5.3.2 (a)	It is recommended that the ward manager ensures staff comply with the guidance and safety alerts issued by Northern Ireland Adverse Incident Centre (NIAIC), DHSSPSNI, HSCB, PHA and other organisations	1	Immediate and ongoing	A system has been created to provide access by staff to relevant alerts issued by(NIAIC), DHSSPSNI, HSCB, PHA and other organisations. Such circulars or guidance documents are also discussed at regular Nurse Forums, ward meetings and via the ward communication book to ensure that staff are aware of actions required to be taken.
38	5.3.2	It is recommended that the trust ensures that the response to and management of all incidents is in keeping with regional safeguarding vulnerable adult procedures.	1	Immediate and ongoing	Accepted and on-going.

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	LORRAINE CLARKE Lorraine Clarke
NAME OF CHIEF EXECUTIVE / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Claire Hay

	Inspector assessment of returned QIP	Yes	No	Inspector	Date
A.	Quality Improvement Plan response assessed by inspector as acceptable	✓		Wendy M'Gregor.	18th December 2014
B.	Further information requested from provider				

Ward Self-Assessment	
Statement 1: Capacity & Consent • **Patients' capacity to consent to care and treatment is monitored and re-evaluated regularly throughout admission to hospital.** • **Patients are allowed adequate time and resources to optimise their understanding of the implications of their care and treatment.** • **Where a patient has been assessed as not having the capacity to make a decision there are robust arrangements in place in relation to decision making processes that are managed in accordance with DHSSPS guidance.** • **Patients' Article 8 rights to respect for private and family life & Article 14 right to be free from discrimination have been considered**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
Patient's and/or carers have their individual care and treatment plan explained to them and are invited to be involved in the decision making process in relation to their care, treatment & discharge planning. Patient's (if able) /or their carers sign their care documentation. The use of easy read leaflets, communication aids and support of family, friends & cares are involved if the patient wishes as sources of support for the patient. Patient's in Brook Lodge have VOCAL advocacy service available – an information leaflet, including easy read is available and staff will explain and assist in the referral to VOCAL. Staff are guided by the DOH's 'seeking consent – working with people with learning disabilities' guidance, alongside DOLs guidance, Human Right's Act 2000, MH (NI) Order 1986. All staff have restrictive interventions training, with 2 staff having attended 'mental capacity & decision making in LD training'. A file on consent, capacity, decision making is available for staff guidance on the ward. A weekly MDT ward round is held each Friday in Brook Lodge & patient's & their carers are invited to attend, along with other meetings which are arranged in respect of the patient's care, treatment & discharge planning. The WHSCT visiting policy is available and relatives can make alternative arrangements for visiting with the N.I.C.., with mealtimes protected. Patient's have access to postal services and a telephone whilst in hospital & their named nurse will give information on this. A DVD which will show the patient's journey from admission to discharge is currently being produced by the Lilliput Theatre company and should be available by July 2014. Brook Lodge has an information leaflet available and a booklet(easy read) is being devised which will help explain the care & treatment when in hospital. The complaints procedure, MH review tribunal , the role of RQIA , the patient's client council, access to advocacy services will be explained to	5

the patient and leaflets are available for patient's explaining these services. A capacity assessment is currently completed by a senior medical staff and senior psychologist in circumstances where best interest decisions are made and there is either a refusal to cooperate or there is a dispute.	
Inspection Findings: FOR RQIA INSPECTORS USE Only	
Policies, procedures and Department of Health Guidance in relation to Capacity to Consent and Best Interests were available to staff on the ward. Inspectors reviewed training records and noted that all staff working on the ward had attended Capacity Awareness training. Inspectors spoke with the family member of one patient. The family member stated they were invited to all their relatives multi-disciplinary and resettlement meetings and were consulted in any decision making about their relatives care. The relative stated that their wishes were considered eg where their relative was going to live. Inspectors spoke with one patient who stated they had attended their multi-disciplinary and resettlement meetings and had an advocate to support them. Inspectors reviewed care documentation in relation to four patients. Inspectors found that it was not documented whether patients had capacity, or what each patient's level of understanding was for each of the care plan interventions recorded. The care plans did not detail how staff would know if a patient was consenting or not, what action staff take to ensure patients understand their care and treatment, or what staff do when a patient does not consent. Inspectors spoke to four staff in relation to Capacity to Consent. Two of the four staff informed inspectors there were no patients on Brooke Lodge that required a capacity to consent assessment or a best interest decision making assessment completed. All four staff demonstrated their knowledge of the patients' needs and informed inspectors how they would know if a patient was or was not consenting. Staff also informed inspectors of the steps they would take to establish if a patient was consenting, eg give patients information and time to understand. The four staff interviewed also informed inspectors of the action they would take if a patient was not consenting eg stop the activity and return another time. Inspectors were informed by the deputy ward manager that patients are invited and do attend their multi-disciplinary meetings when appropriate. Inspectors reviewed the multi-disciplinary minutes for ten patients. Discussions with patients before and after the multi-disciplinary meetings were not consistently recorded in the minutes. There was also inconsistency with patient signatures. Reasons for patient's non-attendance or where outcomes were not discussed was not recorded.	Not compliant

There was no documented evidence in the multi-disciplinary meeting minutes or care documentation of how patients had been given time to understand the implications of their care and treatment or how staff ensure the patients understand the implications. There was no evidence in the care documentation reviewed that staff have sought consent before supporting or providing any care to the patient. Consideration to Human Rights Article 8 respect for private and family life and Article 14 right to be free from discrimination was not documented in the four sets of care documentation reviewed.	

Ward Self-Assessment

Statement 2: Individualised assessment and management of need and risk • **Patients and/or their representatives are involved in holistic needs assessment and in development of related individualised, person-centred care plans and risk management plans** • **Patients with communication needs have their communication needs assessed and there are appropriate arrangements in place to promote the patient's ability to meaningfully engage in the assessment of their needs, planning and agreeing care and treatment plans and in the review of their needs and services.** • **Assessment of need is a continuous process and plans are revised regularly with the involvement of the patient and/or their representative and in accordance with any changes to assessed needs.** • **Patients' Article 8 rights to respect for private and family life have been considered.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
Patient's, their carers and other professionals involved in their care are involved in the development of individualised care planning and risk management plans from admission. They are encouraged to attend the weekly ward round each Friday with their family, carers and other professionals involved in their care, treatment & discharge planning to provide the optimum level of support required for discharge. Patients have their communication needs assessed and detailed in person centred care plans – referrals are made to speech & language therapy as required and alternative methods of communication – communication books, boards, cards are used where needed. If required an interpreter service is accessed. Communication care plans are reviewed regularly by the named nurse. Patients have access to their mail; phone calls and the use of mobile phones are discussed and agreed with named nurse on admission. The WHSCT visiting policy is available or alternative visiting arrangements are made with the N.I.C. Home leave arrangements are made at the weekly ward round and with consultant (if detained under MHO). The patient is encouraged to be involved in all aspects and decisions in relation to their care & treatment.	5

Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
Inspectors spoke with one family member on the day of the inspection. The family member informed inspectors that they had been involved in assessments in relation to the care and treatment of their relative. Inspectors reviewed care documentation in relation to four of the eight patients on the ward. In the four sets of care documents reviewed, inspectors found that one patient had a Roper, Logan and Tierney assessment completed, two patients had an Orem assessment completed in addition to a Roper Logan and Tierney and one patient had a generic type nursing assessment which did not include an assessment the patients complex needs in relation to the patients learning disability. The rationale for the use of each particular assessment was not clear. Assessments reviewed by the inspectors lacked detail about the patients' needs and activities of living were incomplete. For example, activities such as communication, sleep, sexuality and dying were not complete or lacked comprehensive detail, patients' choice and their likes and dislikes was not consistently documented. Where patients had not signed their assessments, a reason for this was not recorded. On review of the four sets of care documentation it was noted that all four patients presented with behaviours that challenge. However, there was no comprehensive assessments completed in relation to the patients' behaviours and there were no plans in place to proactively support patients and positively manage their presenting behaviours. Inspectors spoke with four staff who described how they support patients who present with behaviours that challenge. Staff detailed the use of proactive strategies, were aware of triggers and how each individual patient presented when becoming distressed. Staff were able to inform inspectors of diversionary techniques they would use when a patient was presenting with signs of distress. However, theses types of interventions were not included in the care plan to guide the care and practice of all staff working on the ward and ensure a consistent approach. Inspectors noted in four of the eight sets of care documentation reviewed that comprehensive risk screening tools were not completed fully in line with guidance.. A decision as to whether the patient required a comprehensive risk assessment or not was not recorded or signed by the appropriate person. There was no evidence that the comprehensive risk assessment had been discussed with the patient or their representative, or a rationale recorded why patients or their representatives had not been involved. Where patients had a comprehensive risk management plan in their care documentation, these were incomplete or not completed correctly for example where it was clear in the patients care plan, that there had been a high level of vulnerable adult referrals completed in relation to assault on other vulnerable adults, this had not been completed in the comprehensive risk assessment or a comprehensive risk management plan put in place. Comprehensive risk management plans had not been completed by the appropriate multi-disciplinary team, patients care managers were not involved and it was unclear who was co-ordinating the plan. There was no	Not compliant

evidence that any of the four comprehensive risk assessments had been reviewed. Information sharing regarding the outcome of the comprehensive risk assessment was not shared with the relevant people eg Vulnerable Adult Designated Officer had made a recommendation that a comprehensive risk assessment and management plan be completed and had not been informed that one had been completed since the vulnerable adult referrals. In the four sets of care documentation reviewed assessments in relation to how a patient communicates lacked detail. For example it was documented that a patient communicated non -verbally, there was no explanation as to what this meant. It was good to note that the four staff interviewed by inspectors knew the patients very well and described how patients communicated, and how they adapted their own communication to meet the patient's needs. Staff members informed inspectors how they would know if a patient was becoming distressed or how patients indicated their needs. However, this vital information was not included in the patients' assessments and care plans and staff on the ward who are familiar with the patients had not had the opportunity to be involved in the completion of these documents. There was no reference in the patients care documentation that staff had considered Human Rights Article 8 rights to respect for private and family life.	

Ward Self-Assessment	
Statement 3: Therapeutic & recreational activity • **Patients have the opportunity to be involved in agreeing to and participating in therapeutic and recreational activity programmes relevant to their identified needs. This includes access to off the ward activities.** • **Patients' Article 8 rights to respect for private and family life have been considered.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
Patients and/or carer's will be involved in agreeing meaningful & therapeutic activities while in hospital. A record is kept of activities attended, the patients individualised care plans will detail a daily activity schedule for each patient, with daily recordings demonstrating activities attended and participation or indeed refusal to attend monitored and recorded. Patients have the opportunity through talking to named nurse or through patient forum meetings to request/suggest alternative activities. Ward staff will strive to assist the patient to continue with day opportunities attended prior to admission within the constraints of distance & resources, getting advice from patient and medical staff on fitness to attend these while in hospital. The patient's in Brook Lodge currently access day opportunities at The Berryburn Centre, in Lakeview Hospital, Maybrook ATC, Benbradagh Day Centre, Sow & Grow garden centre. Several patient's in Brook attend evening activities off site at something special, bowling alley, special Olympics, destined, bus runs, walks and other organised activities. Patient's will have access to mail, phone calls and visits from family and friends – adhering to relevant policies & guidelines whilst in hospital.	5
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
On the days of the inspection, inspectors observed staff engaging patients in activities, such as walks, supporting patients to attend day care and foot spa. Inspectors were shown around the day care facility situated within the hospital site. Activities available in the "Berryburn" day care facility were as follows, art, white sensory room, dark sensory room, soft play area, multi-sensory room, therapy/beauty room, Jacuzzi. It was good to note that patients could access the "Berryburn" day care facility during the evenings and weekends with staff support. Patients had access to several outdoor spaces. Patients had access to other day time activities within the hospital site such as "Sow and Grow" garden centre and a day centre outside the hospital site.	Moving toward compliance

Inspectors spoke to one family member who stated their relative attends day care two days per week, the family member explained why at present two days was sufficient and that they had been involved in the discussions around this. Inspectors reviewed four of eight sets of care documentation. There was no evidence of individualised therapeutic and recreational programmes. Inspectors were informed by the deputy ward manager that patient attendance at day care varied and was according to the patients assessed needs however there was no evidence in four of the eight sets of care documentation reviewed of this assessment, patient choices, likes and dislikes and there was no recorded rationale for this decision. A recommendation has been made in relation to this. One patient interviewed stated they took part in social activities of the ward, and attended special Olympics weekly. The patient also confirmed they attend the "Sow and Grow" gardening centre situated on the hospital site. Inspectors spoke to another patient returning from the "Berryburn centre" the patient stated they had enjoyed the daycentre and activities they participated in. A ward / group therapeutic and recreational activity programme was not available on the ward. Inspectors were informed by the deputy ward manager that when patients do not attend day care they may go out on the bus for a drive or go for a walk, or into town. Without a planned schedule available on the ward patients were not aware of what was happening in their day. Inspectors were informed by the four staff spoke to what patients' likes and dislikes were in relation to social and therapeutic activities. The deputy ward manager informed inspectors that it would be difficult to provide a structured day for one patient, because of the risk of distressing the patient should the activity not occur. There was no consideration given to looking at ways of proactively working with a patient who may experience distress if their routine or plans change. It was good to note that there was evidence of monitoring of patient participation in the care documentation. There was no evidence in the patient care documentation that consideration had been given to patients' Human Rights Article 8 rights to respect for private and family life.	

Ward Self-Assessment

Statement 4: Information about rights • **Patients have been informed about their rights in a format suitable to their individual needs and access to the communication method of his/her choice. This includes the right to refuse care and treatment, information in relation to detention processes, information about the Mental Health Review Tribunal, referral to the Mental Health Review Tribunal, making a complaint, and access to independent advocacy services.** • **Patients' Article 5 rights to liberty and security of person, Article 8 rights to respect for private and family life and Article 14 right to be free from discrimination have been considered.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
Patients are informed of their rights on admission – an easy read human rights leaflet is available on the ward. A leaflet on rights while detained under MHO is given to the patient, nursing staff read & explain these rights to the patient to help them understand their rights, using any communication aids needed and the patient is asked to sign to say they have received this, these are held in medical records, who retain copies of forms NP3 & 5, which detail that patient has been read their rights. The patient's NOK, with their consent, will also receive this leaflet. The MHRT process is explained to the patient when detained and staff will assist the patient to request a review. The complaints procedure & easy read leaflet are available on the ward and explained to patients. An independent advocacy service, through VOCAL is available for patients in Brook Lodge.	5
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
One family returned questionnaire stated their relative had not been given information in a format that met their needs in relation to how to make a complaint. However information in relation to how to make a complaint was available in several formats, such as the use of words, symbols and pictures. Information in relation to accessing advocacy services was available on the ward. One patient stated they could access their advocate and described the nature of support the advocate provided. Inspectors reviewed the ward information booklet, which was in easy read format. The booklet contained information explaining why the patient had been admitted, the use of the telephone, the ward "do and don'ts" the multi-disciplinary team, where to store personal belongings, making a complaint, keeping safe, and stopping infection. The ward	Moving towards compliance

booklet did not include details of any outside agencies the patient may contact when concerned about their care and treatment for example RQIA, Ombudsman GMC or NMC. Easy read information was available for patients on; How the ward use information about the patient, the Mental Health Order and how patients can comment on their care and experience in Brooke Lodge. The four staff interviewed knew how to access and effectively use advocacy services. The deputy ward manager informed inspectors that the independent advocate attends patients' resettlement meetings. Patient forum meetings were held on the ward on 4 April 2014, 7 May 2014, 7 July 2014 and 7 August 2014. Inspectors reviewed the minutes of the meetings and noted there was a record of patients and staff attending the meetings and the agenda. Agenda items discussed at the meetings included, RQIA easy read findings of a Patient Experience Interview inspection, new garden furniture and social activities the patients wanted to participate in such as buying in takeaway food, going to the cinema, trips, and movie evenings. In the four of eight sets of care documentation reviewed inspectors noted one reference made to Human rights in relation to restrictive practice in one set of care documentation the article number was not recorded. There was no reference to Article 5 rights to liberty and security of the person, Article 8 rights to respect for private and family life, Article 14 rights to be free from discrimination.	

Ward Self-Assessment

Statement 5: Restriction and Deprivation of Liberty • **Patients do not experience "blanket" restrictions or deprivation of liberty.** • **Any use of restrictive practice is individually assessed with a clearly recorded rationale for the use of and level of restriction.** • **Any restrictive practice is used as a last resort, proportionate to the level of assessed risk and is the least restrictive measure required to keep patients and/or others safe.** • **Any use of restrictive practice and the need for and appropriateness of the restriction is regularly reviewed.** • **Patients' Article 3 rights to be free from torture, inhuman or degrading treatment or punishment, Article 5 rights to liberty and security of person, Article 8 rights to respect for private & family life and Article 14 right to be free from discrimination have been considered.**	**COMPLIANCE LEVEL**
Staff in Brook Lodge adhere to the WHSCT policy on the use of restrictive interventions and the risk assessment (appendix B) of this policy is completed for each patient and an individual care plan formulated for each patient where the use of restrictive interventions are indicated in the patient's best interest and the reason for use clearly documented. Brook Lodge & Lakeview hospital have locked doors on a swipe system, which can be opened by staff at any time and this is reflected in a care plan. The use of MAPA , as a last resort is clearly documented and explained to the patient – an easy read leaflet is available on MAPA. An individualised care plan will detail the right skills to use for each patient, if needed. The use of MAPA is recorded and monitored. All staff in Brook Lodge, have MAPA training and all staff have training in restrictive interventions. The patients human rights are taken into consideration in formulating care plans to manage risks.	5
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
Training records reviewed during the inspection showed that all staff had received up to date training on the Management of Actual or Potential Aggression (MAPA) and Restrictive Practice/ Human Rights and Deprivation of Liberty. Inspectors reviewed four of eight sets of care documentation. Inspectors noted the WHSCT policy on the use of	Not compliant

restrictive interventions with adult service users and risk assessment (appendix B) had been completed for each patient. However, this risk assessment was generic and did not address the specific needs for the patient population within Brook Lodge who present with complex behaviours that challenge. In the absence of specific assessments and interventions in relation to behaviours that challenge, the only means available to support patients and manage their behaviours that challenge is through the use of reactive strategies which do not adequately address the presenting problem. Each patient had "an Application of Restrictive Interventions" completed. This provided staff with the type of restrictive intervention to be used when generic interventions had not been successful. Inspectors were concerned that in the absence of specific assessments and associated proactive behavioural support plans, these restrictive interventions could be viewed and used. A recommendation has been made in relation to this.

Inspectors reviewed three incidents where physical intervention had been used. Adherence to the WHSCT Policy on the use of restrictive interventions with adult service users was not evident; none of the appendix B monitoring forms had been completed in the four sets of care documentation used as staff were recording on a separate monitoring form. Inspectors did not see any evidence of consideration to alternatives, any completed capacity to consent assessments, any information had been given to patients and or their representatives and effective documentation of all meetings, assessments, consultations and care plans. There was no evidence of any debrief meetings or post incident meetings and no evidence where learning from the incidents had been identified and shared. One staff member stated that they had not been supported after an incident of assault by a patient

On the days of the inspection, inspectors reviewed care documentation relating to four of the eight patients on the ward. Inspectors noted that all of the patients were presenting with behaviours that challenge resulting in the use of physical interventions. There was no evidence of care interventions to guide staff on ways to proactively and positively address the behavioural presentation. Inspectors were informed by the deputy ward manager that patient's behaviour was not being assessed and recorded in patient care documentation using recognised assessment tools however information relating to patients presentation was captured on Trust incident (DATIX) forms following incidents on the ward. It was good to note that four staff interviewed informed inspectors of proactive strategies they utilised with patients, staff were also aware of triggers and patient presentation when patients were becoming distressed. However, this information was not recorded in the care documentation which should be used to inform and guide care practices.

On the days of the inspection there were no patients detained in accordance with the Mental Health (Northern Ireland) Order 1986. Inspectors observed entry and exit to the ward was locked and controlled by staff.

In the four sets of care documentation reviewed, each patient had a care plan completed in relation to restrictive

interventions, which indicated that the patient required a locked door. Staff had recorded a description of the behaviour as the rationale rather than the potential risk, therefore the rationale for the use of this level of restriction in terms of necessity and proportionality was unclear. There was no evidence in the documentation of any consideration to alternatives to this level of restriction. There was no evidence that any restrictions including the locked door had been discussed with the patients or their representatives. Consideration to the impact on patients Human Rights Articles 3, 8 or 14 was not recorded in the documentation. Governance arrangements were unclear. Inspectors reviewed minutes of monthly incident review meetings, vulnerable adult referrals and accidents were discussed however the use of physical intervention on the ward was not included on the agenda. Staff on the ward could not inform inspectors how many incidents of physical intervention had been used on the ward in the past month without going through individual care notes.	

Ward Self-Assessment

Statement 6: Discharge planning • **Patients and/or their representatives are involved in discharge planning at the earliest opportunity.** • **Patients are discharged home with appropriate support or to an appropriate community setting within seven days of the patient being assessed as medically fit for discharge.** • **Delayed discharges are reported to the Health and Social Care Board.** • **Patients' Article 8 rights to respect for private and family life have been considered.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
An estimated discharge date is given on admission. Regular MDT meetings are held, the ward round being held each Friday to discuss support and care needed to plan for the individual patient's discharge home. The patient, their family & carers are involved in this process, with the patient's consent. Patient's have access to an independent advocate to support them through this process. Brook Lodge currently have 5 delayed discharges and discharge meetings are on-going. For all patients who are delayed discharges - an advocate is working with them through the discharge planning process. Brook Lodge have currently 3 patients receiving active assessment & treatment, 2 of whom are detained under the MHO.	5
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
On the days of the inspections the discharge for four patients on the ward was described as delayed (resettlement). Inspectors spoke with one family member during the inspection. The family member stated they had been fully involved in their relatives discharge resettlement planning. The family member stated they had been invited and attended the resettlement meetings and their views had always been considered. The family member expressed their concern that an appropriate place had not been identified as yet. Inspectors spoke with a visiting social worker who was supporting a patient to view two potential placements on the days of the inspection. The social worker stated communication between ward staff and community services was good. The social worker identified the lack of suitable community placements as an area of	Moving toward compliance

concern. Inspectors spoke with one patient who stated they had attended their resettlement meetings and were supported by their advocate; the patient expressed their frustration that a suitable placement had not been sourced for them. Inspectors reviewed minutes in relation to resettlement meetings and noted these had occurred on a monthly basis and were attended by patients, their representative (where appropriate), their community key worker, the independent advocate and ward staff. There was evidence in the care documentation of joint working with outside agencies offering a potential placement for patients assessed for resettlement. However there was no evidence in the care documentation of care interventions and support to prepare patients for their move to community. There was no evidence in the four sets of documentation reviewed of occupational therapy or behaviour support input. Inspectors reviewed care documentation in relation to one patient who was admitted for care and treatment following an increase in behaviours that challenge at home. Inspectors noted the patient was due for discharge during the inspection. Inspectors were informed by staff that the patients discharge had been delayed; however there was no clear reason recorded for this. Inspectors did not see any evidence of any multi-disciplinary assessments or therapeutic interventions. The patient had a previous admission in April 2014. Staff had reviewed the care plans written in April 2014 and no changes had been made. There was no evidence in the care documentation that the reason for a second admission had been reviewed by the multi-disciplinary team. It was documented that the patient had received intervention from the behaviour support team and a plan was in place in the community; however there was no evidence of this information / the assessment or behaviour management plan in the patients care documentation. Staff interviewed stated behaviour support plans used in community would be inappropriate as the patient behaved differently when in hospital than at home, yet on review of the documentation it was noted the patient had required physical interventions during their admission.	

Ward Manager's overall assessment of the ward's compliance level against the statements assessed	COMPLIANCE LEVEL
	5

Inspector's overall assessment of the ward's compliance level against the statements assessed	COMPLIANCE LEVEL
	Not compliant