The Regulation and Quality Improvement Authority

RQIA

Mental Health and Learning Disability

Unannounced Inspection

Dorsy Assessment and Treatment Unit, Bluestone Unit, Craigavon Area Hospital

Southern Health and Social Care Trust

4 and 5 November 2014

npm national preventive mechanism

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

Contents

1.0 General Information

Ward Name	Dorsy Assessment and Treatment Unit
Trust	Southern Health and Social Care Trust
Hospital Address	68 Lurgan Road Portadown BT63 5QQ
Ward Telephone number	028 37522381
Ward Manager	Eileen McKeown
Email address	eileen.mckeown@southerntrust.hscni.net
Person in charge on day of inspection	Donna Hanna
Category of Care	Learning Disability assessment and treatment unit
Date of last inspection and inspection type	21 & 22 October 2013
Name of inspectors	Audrey Woods and Siobhan Rogan

2.0 Ward profile

Dorsy ward is a ten bedded mixed gender assessment and treatment unit for patients with a learning disability who require care in an acute inpatient care environment. Inpatient care and treatment had previously been provided in Longstone Hospital. This ward transferred to the Craigavon Area Hospital site in 2014.

On the day of the inspection there were ten patients on the ward. There were five patients who were detained in accordance with the Mental Health (Northern Ireland) Order 1986.

The multidisciplinary team consists of a team of nursing staff and health care assistants, three consultant psychiatrists, two doctors, a behaviour nurse therapist, a psychologist (three mornings a week) and a social worker. At the time of the inspection there was permanent occupational therapist on the ward. An independent advocacy service is also available for patients on the ward.

On the day of the inspection there were five patients on enhanced observation. Four patients had 1:1 observations in place and one patient had

2:1 observations in place. There were four patients on the ward whose discharge was classed as delayed.

Each patient on the ward had their own bedroom with en-suite facilities which were designed to promote patient dignity and privacy. The bedrooms were clean, tidy and clutter free. Bedrooms were noted to be personalised to each patient's likes and preferences. Patients had access to two garden areas. The smaller of the two garden areas was accessible from a number of doors on the ward. The gardens were well maintained and being used by the patients whilst the inspector was on the ward.

The ward had an activity room which could used to set up individualised and group activities for patients. The ward also had a visitors room which was in the main corridor before entering the ward. The entry and exit door to the ward was locked.

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 Dorsy Assessment and Treatment Unit was undertaken on 4 and 5 November 2014.

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

The recommendations made following the last announced inspection on 21 and 22 October 2013 at Longstone Assessment and Treatment Unit, Longstone Hospital, were evaluated. The inspector was pleased to note that three recommendations had been fully met and compliance had been achieved in the following areas:

- The Trust has reviewed the policy and procedures for staff to follow in relation to vulnerable adult referrals in accordance with the 'Safeguarding Vulnerable Adult –A Shared Responsibility (2010)
- The Trust has reviewed procedures in relation to holding small amounts of cash and valuables for patients
- A system is now in place to ensure staff have appropriate training, skills and knowledge to work in the ward

However, despite assurances for the Trust, five recommendations had not been fully implemented. Two recommendations had been partially met and three recommendations had not been met.
Five 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 previous finance inspection

The recommendations made following the finance inspection on 6 January 2014 were evaluated. The inspector was pleased to note that the recommendation made had been met in full compliance had been achieved in the following areas:

- Receipts are marked with the patients name to clearly identify the owner of the receipt.

Details of the above findings are included in Appendix 1.

5.0 Inspection Summary

Since the last inspection the inspectors found progress had been made in relation to the availability of easy read information on the ward for patients in relation to the mental health order, information on the Dorsy unit, patient's rights whilst in hospital and information on the Managing of Actual and Potential Aggression (MAPA) approach. Patients had individual timetables in place which were also in easy read format.

The ward was relocated from Longstone Hospital, Armagh to Dorsy on the Criagavon Area Hospital site in June 2014. This new unit is a purpose built ward which provides the patients with their own bedroom and en-suite facilities.

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.

It was good to note that out of the 12 questionnaires which were completed by staff prior to the inspection, 11 staff members indicated that they had received training in relation to capacity to consent and human rights.

It was good to note there was easy read information available for patients in relation to the mental health order, the occupational therapy service, information on the Dorsy unit, patient's rights whilst in hospital and information on the Managing of Actual and Potential Aggression (MAPA) approach. Patients also had individual timetables in place which were also in easy read format.

The inspectors spoke to three patients on the ward who all stated they had been involved in their care and treatment on the ward. They advised the nurses and doctors had spoken to them about their care and treatment and they understood the plans that were in place

Inspectors reviewed three sets of care documentation and there was evidence in one of the three sets of care documentation that a capacity assessment had been completed. However there was no evidence of patients, relative/carers or an advocate being involved in this assessment. There was no evidence that capacity assessments had been completed for two of the three patients. The inspectors were concerned to note that capacity assessments had not been completed for all patients on the ward, as all patients have restrictions in place in relation to deprivation of their liberty as the ward is a locked environment. The multi-disciplinary weekly ward round template indicated that each patients capacity was being reviewed. However these records were inconsistently completely each week and there was no evidence to support the patient's capacity having been assessed or reviewed. Recommendations have been made in relation to this.

There was no evidence in the three sets of care documentation reviewed by the inspectors to guide staff if patients refused care and treatment and there was no record of this in the continuous progress notes. A recommendation has been made in relation to this.

The inspectors reviewed the care documentation of the patient who had been assessed as not have capacity to consent to their care and treatment. There was no evidence in the patients care documentation of a multi-disciplinary discussion in relation to arrangements in place for decision making processes for this patient. There was no record that a best interest and decision making checklist had been completed. A recommendation has been made in relation to this

The inspectors reviewed three sets of care documentation and there was evidence that comprehensive care plans, assessments and comprehensive risk assessment had been completed by the community team prior to the patients being admitted onto the ward. There was evidence that nursing staff had completed a nursing assessment when patients were admitted onto the ward and care plans were implemented from these assessments. These care plans were individualised however there was no record that care plans had been reviewed by staff on the ward throughout the patients admission. A recommendation has been made in relation to this

The inspector reviewed three comprehensive risk assessments which had been completed. There was evidence that these assessments had been reviewed however this was not on a regular basis. Assessments reviewed by the inspectors were detailed and comprehensive however there was no evidence of involvement from patients, carers/relatives or advocates in the completion of the assessment. A recommendation has been made in relation to this

A new multi-disciplinary meeting template (MDT) had been introduced onto the ward to record who attends the meeting, the discussions that have taken place and planned action points. However, the inspectors reviewed three set of care documentation and there was inconsistent records completed for patients. There was no evidence in some of the records of what had been discussed and agreed at the meeting. Therefore it was unclear what plans had been agreed for the patients. In the three sets of care documentation reviewed by the inspectors there was no record of patients, relatives/carers involvement in meetings and no indication of the reason why they did not attend. In one set of care documentation reviewed by the inspectors there was evidence that the patient's views had been sought prior to one of the multi-disciplinary meeting and there was evidence that staff had met with this patient after the meeting to discuss the outcome. However this was inconsistent and did not happen each week. A recommendation has been made in relation to this

Inspectors spoke to one relative who advised they were updated regularly on their relative's progress when they visit the ward. The relative stated that the care on the ward was "brilliant" and they were "100 % happy" with their relatives care. The stated they could ring anytime to get an update on their relative's progress.

It was good to note that in the three sets of care documentation reviewed by the inspectors there was evidence that care plans were individualised and person centred with reference made to human rights article 8. Out of the three sets of care documentation there was evidence in two sets that patients and relatives had been involved in completing care plans. In one patient's care plan there was no evidence of involvement from patients or carers/relatives. A recommendation has been made in relation to this.

It was clear from information in the patients' care documentation that two patients had issues in relation to sensory problems however there was no

evidence of a sensory assessment been completed for these patients. A recommendation has been made in relation to this

Two of the three sets of care documentation reviewed by the inspectors indicated that patients had problems in relation to their communication needs. However, there was no evidence of speech and language therapy involvement with these patients in relation to setting up communication aids/tools. In one set of care documentation it stated in the patient's care plan to 'adhere to speech and language recommendations re: communication'. However there was no evidence in the file of a speech and language assessment been completed or what the recommendations were. A recommendation has been made in relation to this

In the three sets of care documentation there was no evidence that individualised assessments had been completed for patients in relation to therapeutic and recreational activities. A recommendation has been made in relation to this.

Inspectors completed a direct observation of the ward over the two day inspection period. The inspectors were concerned to note there was no evidence of therapeutic activities taking place for patients on the ward. Patients were observed lying in their beds, walking aimlessly around the ward and garden area. Patients were observed shouting at each other with staff having to intervene. The inspectors observed only one patient taking part in an activity with a member of staff on the ward. Inspectors were advised that two patients attend day care. However there was no evidence of therapeutic or recreational activities in place for the other eight patients on the ward. There were no recreational and therapeutic assessments completed for individual patients to guide staff in carrying out activities. The occupational therapist had not been on the ward since 19/8/14. Inspectors noted that staff were not actively engaging with the patients; communication was basic and they did not seem to be encouraging patients to take part in activities. Staff were observed completing enhanced observations with patients. They did not use this opportunity to engage meaningfully with the patient. One staff member was observed sitting reading a magazine and ignoring the patient. However when another staff member took over they were observing chatting to the patient and involving them in conversation. Three of the four professionals that spoke to the inspectors raised concerns regarding the lack of activities on the ward for patients. Recommendations have been made in relation to this.

One patient was observed being monitored with enhanced observation by two members of staff in their bedroom. The inspectors observed very little activity been completed with this patient even though there was a psychology and behavioural assessment completed which stated this patient should be involved in pro-active strategies. It stated the patient should be following a "comprehensive structured activity plan" however over the two days of the inspection there was no evidence of any activities being carried out with this patient. Recommendations have been made in relation to this.

Inspectors spoke to one family member who raised concerns regarding the lack of stimulation on the ward for their relative. They advised that they had found it difficult to get staff to embrace previously successful interventions. They felt there was a resistance to other staff from the community visiting their relative on the ward to assist in implementing interventions. They advised they had offered to show staff how to work with their relative but this was declined. They were very concerned about their relative been bored on the ward which increased their level of frustration, leading to increased episodes of challenging behaviour. A recommendation has been made in relation to this.

There was evidence of a considerable increase in the use of seclusion, the use of the low stimulus room and episodes of restraint. There had been five staff assaulted on the ward over the past two months by patients and they were now on sick leave. This had resulted in increased levels of banking staff on the ward. The inspectors were concerned regarding the increased levels of restrictive practices on the ward and the increased levels of challenging behaviours. The inspectors were advised by the nurse in charge that the clinical director is aware of the current situation in the ward and an action has been agreed in relation to the above issues. Recommendations have been made in relation to this.

Inspectors were informed by the nurse in charge of the ward that there were five patients on the ward who were detained in accordance with the Mental Health (Northern Ireland) Order 1986. It was good to note there was easy read information available on the ward for these patients in relation to their rights under the Mental Health (Northern Ireland) Order 1986.

Information was displayed in the ward notice board on how to make a complaint and how to access the independent advocacy service. This was also in easy read format. The ward has access to an advocate who meets with all patients on the ward to provide support. When inspectors spoke to three patients on the ward they were all aware of the advocacy service.

All three sets of care documentation reviewed by the Inspectors indicated that the patients were detained in accordance with the Mental Health (Northern Ireland) Order 1986. It was good to note that individual care plans had been developed in relation to this process. These detailed the importance of giving patients information on the detention process in an appropriate easy read format, having discussions with patients around the detention process and making sure patients have access to the advocacy service on the ward.

Inspectors noted in the three sets of care documentation that individualised care plans were in place for all three patients in relation to restrictive practices. A number of care plans detailed a clear rationale around the restriction in place however there were care plans in place which did not have a clear rationale. There was evidence in two of the three sets of care documentation that patients and their relatives had been involved in completing care plans. There was no evidence in one set of care documentation that patients or their relatives/carers had been involved in the patient's care plan. There was no evidence in the three sets of care

documentation that care plans were reviewed regularly by staff on the ward. Recommendations have been restated in relation to this.

There was reference throughout the care plans reviewed by the inspectors that staff had considered the potential impact of restrictive practice on the patients human rights in relation to articles 3, 5, 8 and 14.

It was good to note that out of the 12 questionnaires which were completed by staff prior to the inspection, 11 staff members indicated that they had received training in relation to restrictive practice

Inspectors reviewed three sets of care documentation and noted patients did not have a nursing discharge care plan completed and there was no record of discharge planning meetings having been held therefore inspectors could not identify who was responsible for co-ordinating and progressing patients discharge from hospital. The inspectors spoke to one relative who stated that a discharge planning meeting had been arranged for their relative. However in the care documentation there was no evidence of a discharge plan for this patient. Notes relating to patients discharge plans were recorded in the multi-disciplinary case conference record. However this was inconsistent throughout the three sets of care documentation reviewed by the inspector. There was no evidence that relative/carers or patients had attended these meetings or a reason why they did not attend. Recommendation have been made in relation to this.

Inspector spoke to a relative of one of the patients on the ward whose discharge was classed as delayed as there had been difficulties finding a suitable placement for this patient in the community. This relative stated they felt there was a lack of collaborating with community based professionals to assist in the discharge arrangement for her relative. They felt it was left up to then to source a suitable placement in the community. When inspectors spoke to members of staff regarding discharge planning staff stated that patients were waiting for suitable placement in the community and they recognised there was very little focus on the discharge plans for these patients, as there were problems finding suitable placement. Recommendations have been made in relation to this.

Although on the days of the inspection there were some improvements identified in relation to patients care and treatment, there were also a considerable number of areas that require improvement which has reflected in the overall compliance level in this report.

Details of the above findings are included in Appendix 2.
On this occasion Dorsy 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	**3**
Ward Staff	**3**
Relatives	**2**
Other Ward Professionals	**4**
Advocates	**1**

Patients

Inspectors spoke to three patients on the ward. All three patients stated they knew why they were in hospital and knew what they could and could not do on the ward. All three patients stated they had been involved in their care and treatment. The patients were all aware that there was an advocacy service on the ward. One patient informed the inspectors that the advocate had met with them to discuss discharge plans. Two patients stated that they attend day opportunities during the week and they enjoy going each day. However, one patient stated that they do not have anything do to on the ward when they return from day care. Inspectors discussed various tasks the patient could complete on the ward and they agreed that it would be good to have more tasks to do to "keep busy". One patient stated that they were waiting on a placement in the community and they "couldn't wait to get out of this place". A placement had been set up for this patient but it was unsuccessful and the patient had to return to the ward. The patient appeared unsettled and annoyed about this. This patient also stated that they would like a key to their bedroom door so that they could lock it when they are not using the bedroom. It was good to note that all three patients stated they were overall satisfied with the care they were receiving on the ward. Patients stated "it's been good on the ward", staff are good here and they look after us". Recommendations have been made in relation to issues raised by patients. The inspectors discussed individual concerns raised by the patients with the nurse in charge on the day of the inspection.

Relatives/Carers

Inspectors spoke to two relatives on the days of the inspection. One relative stated that they were very pleased with the overall care and treatment their family member was receiving on the ward. They stated that the "staff are brilliant, 100%". They advised that they can ring the ward anytime to get anupdate on their relatives condition. They also stated that when there had been concerns regarding their family member during the day staff telephoned to update them later the same night. The relative stated that the staff were all very friendly and helpful on the ward. They advised they were updated

regularly on their relatives care and treatment as they visited their family member every day. However this relative stated they were unaware that multi-disciplinary meetings were held on the ward each week to discuss their relatives progress and they advised if they had known they would have attended.

Inspectors spoke to one family member who raised concerns regarding the lack of stimulation on the ward for their relative. They advised that they had found it difficult to get staff to embrace previously successful interventions. They felt there was a resistance to other staff from the community visiting their relative on the ward to assist in implementing interventions. They advised they had offered to show staff how to work with their relative but this was declined. They were very concerned about their relative being bored on the ward which increased their level of frustration, leading to increased episode of challenging behaviour. They also raised concerns regarding finding suitable accommodation in the community for their relative as they were delayed in their discharge from hospital. They raised concerns regarding how their relative's discharge has been managed. These concerns were raised with senior management on the day of the inspection and it was agreed that a meeting will to be arranged with this family member, a senior manager from the Trust and the family's advocate. Recommendations have been made in relation to issues raised by family members.

Ward Staff

Inspectors spoke to three ward staff who all raised concerned regarding the mix of patients in the unit and how this can be safely managed. They spoke about the rise in challenging behaviours on the ward, the increased use of the low stimulus room and seclusion on the ward. They advised that since staff members had been assaulted and are now on sick leave there has been an increase in the number of bank staff working on the ward. These staff members stated this is not appropriate when working with patients who need continuity and a structured routine in place. The staff stated that the occupational therapist is no longer on the ward and therefore there has been a reduction in activities on the ward due to this. Recommendations have been made in relation to issues raised by staff members. The inspectors discussed these concerns with the nurse in charge on the day of the inspection.

Other Ward Professionals

Inspectors spoke to four ward professionals. One professional stated that they were concerned regarding the increased number of incidents on the ward and the lack of activities. They stated that they had seen benefits of moving to the Craigavon site but acknowledged that the transition had been difficult.

One ward professional stated they enjoyed working in the ward. They raised concerns regarding the limited access to physical health screening for patients in the ward.

One professional stated that they were concerned regarding the number of incidents on the ward and the high levels of staff sickness. They stated that

this makes it difficult to implement programmes of care. They raised concerns regarding the low level of activity on the ward and felt that this was “hard to address”.

One professional stated they work on the ward for three sessions each week and they worked closely with other professionals on the ward. They raised concerns regarding the lack of therapeutic activity on the ward and stated that patients were “bored”. They highlighted that there was a high use of bank staff and they were concerned about the potential implications for patients in terms of consistency. They were also concerned regarding the lack of access to psychotherapeutic or psychodynamic approaches for patients. However the inspectors discussed this with the consultant psychiatrist on the ward who highlighted they were trained in these approaches and agreed to implement these approaches on the ward. Recommendations have been made in relation to issues raised by ward professionals.

Advocates

Inspectors spoke to the advocate the ward who also raised concerns regarding staffing levels, the level of challenging behaviours displayed on the ward and the current mix of patients, the lack of therapeutic activity and the management of resettling some patients into the community. This was discussed with the nurse in charge and a senior manager on the day of the inspection

Questionnaires

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

Questionnaires issued to	Number issued	Number returned
Ward Staff	19	10
Other Ward Professionals	19	2
Relatives/carers	8	0

Ward Staff

Ten questionnaires were returned by ward staff in advance of the inspection. It was good to note that information contained within the staff questionnaires demonstrated that seven out of the ten staff were aware of the Deprivation of Liberty Safeguards (DOLS) – interim guidance. All ten staff members had received training in restrictive practices and were aware of restrictive practices on the ward. Examples of restrictive practices as reported by staff included “locked ward” “low stimulus environment”, “seclusion room”, “1:1 observations”, and “MAPA”. Nine out of the ten staff members indicated they had received training in the areas of Human Rights and capacity to consent.

All ten staff members who returned their questionnaires prior to the inspection stated they had received training on meeting the needs of patients who need support with communication. Staff indicated that patients communication needs are recorded in their assessment and care plan. They indicated they were aware of alternative methods of communicating with patients. All ten staff members stated that these were used in the care setting and that the ward had processes in place to meet patients' individual communication needs on the ward. All ten staff members reported that patients had access to therapeutic and recreational activities and that these programmes meet the patient's needs.

On the days of the inspection the inspectors did not see evidence of therapeutic and recreational activities been implemented on the ward. There was no evidence of alternative methods of communicating been used with patients or evidence that patients communication needs are recorded in their assessment and care plan.

Other Ward Professionals

Two questionnaires were returned by ward professionals in advance of the inspection. It was good to note that information contained within the professionals questionnaires demonstrated that both professionals were aware of the Deprivation of Liberty Safeguards (DOLS) – interim guidance. They had received training in restrictive practices and were aware of restrictive practices on the ward. One professionals stated " all restrictive practices are fully assessed by the MD team and based on the comprehensive assessment of the patient's best interest". The two professionals indicated they had received training in the areas of human rights and capacity to consent.

The two ward professionals who returned their questionnaires prior to the inspection stated they had received training on meeting the needs of patients who need support with communication. Staff indicated that patients communication needs are recorded in their assessment and care plan. They recorded that they were aware of alternative methods of communicating with patients. Both professionals stated that these were used in the care setting and that the ward had processes in place to meet patients' individual communication needs on the ward. The two ward professionals reported that patients had access to therapeutic and recreational activities and that these programmes meet the patient's needs.

On the days of the inspection the inspectors did not see evidence of therapeutic and recreational activities been implemented on the ward. There was no evidence of alternative methods of communicating been used with patients or evidence that patients communication needs are recorded in their assessment and care plan. Recommendations have been made in relation to this.

Relatives/carers

No questionnaires were returned from relatives/carers.

7.0 Additional matters examined/additional concerns noted

Complaints

Inspectors reviewed complaints received by the ward between 1 April 2013 and 31 March 2014. Three complaints from relatives were recorded over this period of time. One was in relation to both environmental issues and care practice. One was in relation to care practice and one was in relation to environmental issues. Two complaints had been resolved to the satisfaction of the relative and one relative was partially satisfied.

Insert details of additional concerns

Inspectors queried the suitability of the ward environment as everyone entering the ward has to come through the main area where the patients are sitting. This can be very distracting and noisy. There are other areas and rooms that could be used by patients on the ward, such as the dining area and the activity rooms. However patients seem to congregate in the main entrance area.

The alarm system is an issue on the ward. When it is raised it is very loud and could be very upsetting for patients on the ward especially patients with sensory problems.

Recommendations have been made in relation to the above issues.

8.0 RQIA Compliance Scale Guidance

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

Appendix 1

Follow-up on recommendations made following the announced inspection on 21 and 22 October 2013

No.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	It is recommended that the Trust review the policy and procedure for staff to follow for responding to, recording and reporting concerns about actual or suspected adult abuse whereby all referrals are reviewed by the ward sister prior to being forwarded to the designated officer to ensure that this is consistent with regional guidance 'Safeguarding Vulnerable Adults – A Shared Responsibility' (2010).	Inspectors were informed by senior management that this procedure has been reviewed. A new gateway team has been established within the trust and staff report and forward all vulnerable adult referrals to this team when screened by the nurse in charge.	Fully met
2	It is recommended that the ward sister ensures that the Deprivation of Liberty Safeguards (DOLS) – Interim Guidance, as outlined by the DHSSPSNI in October 2010, is implemented within the unit.	Inspectors reviewed three sets of care documentation and there was evidence that the Deprivation of Liberty Safeguards (DOLS) – Interim Guidance had been implemented within the unit. However, all restrictive practice care plans had not been completed in accordance with the DOLS guidance. This recommendation will be restated for a second time	Partially met
3	It is recommended that the Trust review all practices in the unit that could be considered restrictive, including the locking of entrance and exit doors to the unit, to ensure that all	The inspectors were informed that the Trust has not reviewed all practices in the unit that could be considered restrictive. This recommendation will be restated for a second time	Not met

	practices are the least restrictive most effective option to promote patient safety and wellbeing. Consideration of the impact on patient's human rights should be included as part of this review		
4	It is recommended that the ward sister ensures that that care plans in relation to actual or perceived deprivation of liberty are reviewed to ensure that an explanation of deprivation of liberty is included and relevant to the plan of care.	Inspectors reviewed three sets of care documentation and there was evidence that care plans had been reviewed. However in the three sets of care documentation the reasons for the restrictive practices were unclear in a number of care plans and therefore it was unclear if the restriction was necessary and proportionate to the restriction imposed on the patients. This recommendation will be restated and a new recommendation will be made	Partially met
5	It is recommended that the Trust ensure that occupational therapy is made available to all patients in the assessment and treatment unit.	On the days of the inspector the inspectors were informed by the nurse in charge that the occupational therapist was no longer working on the ward This recommendation will be restated for a second time	Not met
6	It is recommended that the Trust review the procedures for holding small amounts of cash and valuables at unit level to ensure that there are appropriate safeguards in place for the safety and security of patient valuables. The outcome of this review should be shared with RQIA by	Inspectors were informed that this procedure has been reviewed. Inspectors reviewed records of money held for patients on the ward. Inspectors noted that two members of staff sign when patients receive money into the ward and when money is withdrawn. Patients' money is kept in the safe or in their individual locked cupboards in their bedroom depending on patients own choice.	Fully met

	28 February 2014.		
7	It is recommended that the Trust ensure that a system is put in place so that the ward sister/nurse in charge can ensure that all staff have the appropriate training skills and knowledge to work in the unit.	All bank staff working in the ward have completed mandatory training and have Managing Actual and Potential Aggression (MAPA) training. Bank staff are recruited to the ward through the central banking department. The nurse in charge stated that the ward sister has informed the banking department of the training staff need to complete prior to working on the ward. This department ensures that staff have this training before contacting them .	Fully met
8	It is recommended that the Trust review the care recording processes for all disciplines in the unit to ensure that there is a continuous record of all aspects of care provided to patients in the unit.	In the three sets of care documentation reviewed by the inspectors there was evidence of occupational therapist records medical and nursing records. However, continuous records regarding other disciplines input in the ward in relation to patients care and treatment such as psychology and behaviour nurse therapy input was not evident in the care documentation. A multi-disciplinary template had been introduced onto the ward to record professionals input however, in the three sets of care documentation reviewed by the inspectors this template had not been completed fully. This recommendation will be restated for a second time	Not met

Appendix 1

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

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

Follow-up on recommendations made at the finance inspection on 6 January 2014

No.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	It is recommended that the ward manager ensures receipts are marked with the patient name to clearly identify the owner of the expenditure.	Inspectors noted that receipts were retained for each item purchased by patients whose money is kept in the ward safe. This was countersigned by two members of staff and stored in the record book.	Fully met

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

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

Quality Improvement Plan

Unannounced Inspection

Dorsy Assessment and Treatment Unit, Craigavon Area Hospital

4 and 5 November 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 the nurse in charge, the clinical psychiatrist, the patient bed flow coordinator and the independent advocate on the day of the inspection visit.

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

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
1	5.3.1 (a)	It is recommended that the ward sister ensures that the Deprivation of Liberty Safeguards (DOLS) – Interim Guidance, as outlined by the DHSSPSNI in October 2010, is implemented within the unit.	2	1 February 2015	The Ward Sister will ensure that DOLS-Interim Guidance is disseminated to all staff especially all Registered Staff to ensure this guidance is reflected in the Care Plan. The Ward Sister will monitor compliance. The Guidence is readily available in the ward office for all staff
2	5.3.1 (a)	It is recommended that the Trust review all practices in the unit that could be considered restrictive, including the locking of entrance and exit doors to the unit, to ensure that all practices are the least restrictive most effective option to promote patient safety and wellbeing. Consideration of the impact on patient's human rights should be included as part of this review	2	1 February 2015	A restrictive practice intervention group has been convened the groups remit will include estabilishing clear pathways for reviewing restrictive practices. Restrictive Practices are reviewed weekly at Multi-Disciplinary team meetings. Restrictive practice interventions are also discussed at both operational and governance meetings for Dorsy; to ensure patients human rights are considered and least restrictive options are promoted. Patient Advocate input is included in the reviewing of restrictive practices and physical interventions.
3	5.3.1. (a)	It is recommended that the Trust ensure that occupational therapy is made available to all patients in	2	1 February 2015	Senior Occupational Therapist has been allocated to Dorsy during the current OT maternity leave

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
		the assessment and treatment unit			abscence.
4	5.3.1 (f)	It is recommended that the Trust review the care recording processes for all disciplines in the unit to ensure that there is a continuous record of all aspects of care provided to patients In the unit.	2	Immediate and ongoing	The review of care recording processes will be discussed at both Dorsy governance and operational meetings to ensure there is a continuous record of all aspects of care provided by all disciplines to patients on Dorsy. The Division of Learning Disability is in the process of implementing revised Care Record Documentation in community servies and will aim to use the same documentation in the Dorsy although no timeframe has been set for this.
5	5 .3.1 (a)	It is recommended that the ward sister ensures that that care plans in relation to actual or perceived deprivation of liberty are reviewed to ensure the rationale is based on individual risk assessment to ensure the deprivation of liberty is proportionate and necessary to each individual risk	1	1 February 2015	Restrictive practices which are based on current risk assessments will be reviewed at weekly Multi-Disciplinary meetings to ensure that the least restrictive options are promoted and proportionate to individual risks presented. Restrictive intervention care plans will reflect this.
6	5.3.1 (f)	It is recommended the multi-disciplinary team ensures that all	1	1 February	The Multi- Disciplinary team to discuss capacity assessments at operational and governance

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
		patients have a capacity assessment completed and that this is monitored and re-evaluated regularly by the multi-disciplinary team throughout the patient's admission to hospital.		2015	meetings and devise a protocol on completing capacity assessments for all patients and reviewing in the multidisciplinary team meeting.
7	5.3.1 (a)	It is recommended that the ward sister ensures that when patients have been assessed as lacking capacity to consent to their care and treatment that there are robust arrangements in place in relation to decision making processes that are managed in accordance with DHSSPS guidance	1	Immediate and ongoing	The Ward Sister ensures that for those patients assessed as lacking capacity to consent to their care the documentation will reflect arrangements agreed by the Multi-Disciplinary Team for these patients in the decision making processes. This will be discussed at both the governance and operational meetings. The Ward Sister and responsible Medical Officer will ensure compliance with best practice guidance.
8	5.3.3 (b)	It is recommended that the ward sister ensures that patients and or their relatives/carers/advocates are involved in formal assessments in relation to capacity to consent and that there is a clear documentation of who was involved in the patients care	1	Immediate and ongoing	The Ward Sister and Responsible Medical Officer will promote best practice regarding capacity assessments for patients. Patients, relatives/carers and advocates will be involved in formal capacity to consent assessments. This will be discussed at both the governance and operational meetings. The DMHD has issued

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
		documentation.			guidance for staff in realtion to judgments in relation to capacity and best interests pathways
9	5.3.1 (f)	It is recommended that the ward sister ensures that staff assess patients consent to daily care and treatment and that this is recorded in the patients continuous nursing notes	1	Immediate and ongoing	The Ward sister will ensure that the staff assess patient consent to daily care and treatment and promote that this assessment is reflected/recorded in patient continuous nursing notes. The Ward Sister will monitor compliance.
10	5.3.3 (b)	It is recommended that the ward sister ensures that comprehensive risk assessments are reviewed on a regular basis that patients and where appropriate their relatives/carers have the opportunity to contribute to the comprehensive risk assessment and sign this document, as outlined in the Promoting Quality Care Guidance Document – Good Practice on the Assessment and Management of Risk in Mental Health and Learning Disability Services- May 2010	1	Immediate and ongoing	The Ward Sister and responsible medical officer will ensure that Risk Assessments are reviewed by the Multi-Disciplinary team on a regular basis and record of Promoting Quality Care reviews are completed at weekly ward round.

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
11	5.3.1 (f)	It is recommended that the ward sister ensures that there is a clear record of who attends the MDT meeting and if patient, relative /carers have not attended the reasons why are clearly documented.	1	Immediate and ongoing	The Ward Sister and responsible medical officer will ensure that there is a clear record in the patient notes of attendees at Multi-Discipliary meetings. In the event of a patient, relative or carer who have not attended this meeting it is clearly documented why there is non attendance. This information will be disseminated at both the Dorsy operational and governance meetings. The proforma for MD Meetings will be reviewed.
12	5.3.1. (a	It is recommended that the ward sister ensures that patients have a holistic assessment completed which includes a sensory needs assessment	1	1 February 2015	The Ward Sister and responsible Medical Officer will ensure that patients have a holistic assessments . Recent allocation of the Senior Occupational Therapist is currently facilitating sensory needs assessments.
13	5.3.1 (a)	It is recommended that the ward sister ensures that patients who have been assessed as having communication needs are referred to the speech and language therapist.	1	Immediate and ongoing	The Ward Sister and responsible medical officer will ensure that all patients who have been assessed as having communication needs will be referred to the Speech and Language Therapist.
14	5.3.3 (b)	It is recommended that the ward sister ensure that all patients and	1	1 February	The Ward Sister will ensure that both patients and

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
		relatives are given the opportunity to be involved in completing care plans. If they have not been involved the reasons why should be clearly documented.		2015	relatives are provided with opportunity to be involved in completing care plans also reasons will be documented when patients/relatives have not been involved in the process. Information regarding the process will be disseminated to all staff completing care plans. Dorsy is currently reviewing the implementation of the regional learning disability care plan.
15	5.3.1 (a)	It is recommended that the ward sister ensures that patients have individualised assessments completed for therapeutic and recreational activities and a timetable is set up from this assessment. A record should be maintained in the patients care documentation to ensure ongoing monitoring and evaluation.	1	1 February 2015	The Ward Sister will ensure that all patients will have individual assessments for therapeutic and recreational activities completed. A variety of activities have been established in conjunction with the Occupational Therapist. Activity record will be formulated to facilitate monitoring and evaluation.
16	4.3 (i)	It is recommended that the ward sister ensures that when staff members are involved in completing enhanced observations they manage risks	1	Immediate and ongoing	The Ward Sister will reinforce and disseminate to staff completing observations how best to meet individual patient needs and manage risk. The Team are reviewing the documentation to record and communicate care when a patient is on

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
		but also meet each patients individual needs and that this is documented.			enhanced observations.
17	5.3.3 (d)	It is recommended that the Trust ensures that patients have access to a range of professionals with specialist skills in areas such as sensory assessments, communication assessments, psychological interventions to ensure patients are provided with a holistic assessment and treatment plans	1	1 February 2015	Dorsy operational and governance agendas promote patients access to a range of specialist services within the Trust and liaise with Senior Managers to achieve the best standards for patients. There is access to Ocupational Therapy assessment and a Clinical Psychologist is available for assessments and support.
18	4.3 (n)	It is recommended that the Trust reviews the purpose and function of the ward, and the staffing levels and skill mix to meet the complexity and variety of patients need and to ensure the safety of patients and to provide continuity of care.	1	31 December 2014	The Dorsy unit is now the only inpatient assessment and treatment unit for adults with a learning disability in the Southern Trust and therefore will continue to admit and assess all individuals who are considered for admission. The Crisis Response service will continue to grow in it's role as gatekeeper for admissions. Senior Managers continue to support ways in which to secure consistent additional nursing hours to support Dorsy at times of critical demand. This has been a challenge in recent times. Requests for

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
					additional Nursing hours have not been refused and Occupational Therapist Staff have been allocated. Staffing levels are being reviewed by senior staff to ensure safe and effective staffing levels. Problems securing appropriate supported community packeges to facilitate discharge from Dorsy are likely to continue and require ongoing discussions with Commissioners to fund these high cost packages.
19	6.3.2 (f)	It is recommended that the ward sister ensure that when required staff work in collaboration with community staff and families to ensure patients are appropriately supported in relation to therapeutic interventions	1	Immediate and ongoing	The Ward Sister will promote staff to work collaboratively with both families and community staff and ensure that families and community staff are supported and involved in Multi-Disciplinary Team meetings and agree action plan for therapeutic interventions. Arrangements are in place to ensure that patients are facilitated with activities outside the Hospital environment.
21	8.3 (i)	It is recommended that the ward sister ensures that that staff collaborate with community based professionals so that a co-	1	31 December 2014	The Ward Sister and responsible Medical Officer will ensure that staff collaborate with community based professionals to achieve a co-ordinated Multi-Professional discharge plan to facilitate a

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
		ordinated multi-professional discharge plan is in place to ensure a smooth transition from the hospital to community based care. Care plans in relation to discharge planning should detail progress and actions plans with timescales. Patients and relatives/carers should be invited and involved in discharge planning meetings where appropriate. If they are unable to attend this should be recorded. A record of how this information will be shared with patients' relatives/carers should be included in the patient's care documentation.			smooth transition from hospital to community. The team will review discharge meeting documentation, discharge care plan and discharge checklist which will be completed for all patients. All of the above to be discussed at both the governance and operational meetings. Consideration will be given in relation to the sharing of information with non attendees and recording of this process. Discharge Planning should be evident at the point of admission. Community Staff will be invited to participate in the MD Team meeting to formulate discharge plans.
22	5.3.3.(b)	It is recommended that the ward sister reviews the practice in relation to patients holding their key to their bedroom door.	1	31 December 2014	The Multi-Disciplinary Team will discuss this practice at both the governance and operational meetings. This will be considered on an individual patient basis encorporating a balance between risk and human rights in the hospital environment.
23	4.3 (e)	It is recommended that the Trust	1	31 March	The unit is an assessment and treatment ward and

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
		reviews the purpose and function of the ward to ensure patients on the ward are admitted for the care and treatment the unit has been designed for and to ensure patients with the same type of care needs are admitted onto the ward.		2015	was designed for that purpose. The need for admission is driven by patient need, risk of harm to self and or others and family/carer considerations. It is unrealistic and unachievable to ensure that an admission unit only admits clients with similar needs profiles or to ensure client compatibility and these will remain the variables that the Trust and staff will have to manage.
24	7.3 (k)	It is recommended that the ward sister ensures patients have access to physical health screening.	1	31 March 2015	The physical health needs will be assessed on admission and consideration given to securing appropriate access to physical health secreening while an inpatientt
25	7.3 (a)	It is recommended that the Trust review the alarm system in the ward and ensures patients are managed in an environment which provides them with a therapeutic positive experience.	1	31 March 2015	Contact has been made with the Estates Department to reduce the volume of the alarm system. The volume set will be balanced with the need to ensure the safety of patients and staff in an emergency.

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	Acting Sister Angela Cullen
NAME OF CHIEF EXECUTIVE / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Miceal Crilly on behalf of Mairead McAlinden

Inspector assessment of returned QIP				**Inspector**	**Date**
		Yes	**No**		
A.	Quality Improvement Plan response assessed by inspector as acceptable	x		Audrey McLellan	**8/1/15**
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:	
On Admission, a patient's capacity to consent to care and treatment is determined by the Multi-Disciplinary Team. A review of capacity of consent is taken at the weekly Multi-Disciplinary ward rounds also. Consent to care and treatment is continually monitored and regularly evaluated e.g. patient satisfaction questionnaire is given on all discharge and any issues revised, actioned. Patients who have been deemed not to have capacity to consent by the M.D Team are supported in the decision making process around their care and treatment in accordance with Best Interest Pathway and DHSSP guidance. A clear and concise explanation of all treatment and procedures is given to the patient in a format suitable to their level of understanding and communication needs. Easy read versions are given as appropriate for e.g. complaints. Human Rights Mental Health Order. Patients are given adequate time and support to help them understand the implications of their care and treatment, and will be facilitated throughout their hospital stay. Access to an Independent Advocate Service is available for all patients and carers	Compliant

Patient's right to respect and dignity is paramount at all times and families and carers are facilitated to visit the unit during their family member's stay in hospital. (Article 8) All patients are treated equally and free from discrimination. (Article 14)	
Inspection Findings: FOR RQIA INSPECTORS USE Only	
It was good to note that out of the 12 questionnaires which were completed by staff prior to the inspection, 11 staff members indicated that they had received training in relation to capacity to consent and human rights There was evidence in the three sets of care documentation reviewed by the inspector that patient's human rights had been considered with reference to human rights articles 8 and 14. It was good to note there was easy read information available for patients in relation to the mental health order, the occupational therapy service, information on the Dorsy unit, patient's rights whilst in hospital and information on the Managing of Actual and Potential Aggression (MAPA) approach. Patients also had individual timetables in place which were also in easy read format. The inspectors spoke to three patients on the ward who all stated they had been involved in their care and treatment on the ward. They advised the nurses and doctors had spoken to them about their care and treatment and they understood the plans that were in place. Inspectors reviewed three sets of care documentation and there was evidence in one of the three sets of care documentation that a capacity assessment had been completed. However there was no evidence of patients, relative/carers or an advocate being involved in this assessment. There was no evidence that capacity assessments had been completed for two of the three patients. The inspectors were concerned to note that capacity assessments had not been completed for all patients on the ward, as all patients have restrictions in place in relation to deprivation of their liberty as the ward is a locked environment. The multi-disciplinary weekly ward round template indicated that each patients capacity was being reviewed. However these records were inconsistently completely each week and there was no evidence to support the patient's capacity having been assessed or reviewed. Recommendations have been made in relation to this. There was no evidence in the three sets of care documentation reviewed by the inspectors to guide staff if patients refused care and treatment and there was no record of this in the continuous progress notes. A recommendation has been made in relation to this.	Not Compliant

The inspectors reviewed the care documentation of the patient who had been assessed as not have capacity to consent to their care and treatment. There was no evidence in the patients care documentation of a multi-disciplinary discussion in relation to arrangements in place for decision making processes for this patient. There was no record that a best interest and decision making checklist had been completed. A recommendation has been made in relation to this.	

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:	
On Admission patients are individually assessed and a person centred plan is developed to meet the individual's needs in conjunction with the patient and their family/carer. Each patient is allocated a Named Nurse who is responsible for that patient during their admission. Patients are given opportunity to engage in daily 1:1 therapeutic session with a trained Learning Disability nurse and same recorded in nursing notes. Initial screening on admission will determine if a comprehensive Risk Assessment requires completion. A management plan for any identified risk is completed in keeping with Promoting Quality Care Guidance. All patients' communication needs are assessed on admission and referred to Speech and Language Therapist for specialist input if necessary. Easy read documentation is available to support the patient with their communication needs and help them understand their care and treatment.	Compliant

Communication tools such as Communication Boards are used to assist the patient in the communication process. Assessment of communication needs is on-going and regularly reviewed with the patient's family and Speech and Language Therapist. Patients are informed of the Independent Patient Advocate Service who will meet with patients on a 1:1 basis and then liaise with the appropriate discipline on their behalf. Respect for private and family life is paramount, and family/carers are facilitated to visit their relative during their stay in hospital. (Article 8)	
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
It was good to note that there was easy read information available on the ward for patients in relation to the Dorsy Unit which included: staff members roles, what you are allowed and not allowed to bring into the ward, visiting times, facilities in the unit, treatment plans, recreational and therapeutic activities, meetings held, the policy in relation to smoking, using mobile phones and how to make a complaint. There was also an easy read evaluation record for patients to complete prior to leaving the ward, so that staff were able to gain patients views on their experience of being a patient on Dorsy Unit The inspectors reviewed three sets of care documentation and there was evidence that comprehensive care plans, assessments and comprehensive risk assessment had been completed by the community team prior to the patients being admitted onto the ward. There was evidence that nursing staff had completed a nursing assessment when patients were admitted onto the ward and care plans were implemented from these assessments. These care plans were individualised however there was no record that care plans had been reviewed by staff on the ward throughout the patients admission. A recommendation has been made in relation to this The inspector reviewed three comprehensive risk assessments which had been completed. There was evidence that these assessments had been reviewed however this was not on a regular basis. Out of the three risk assessments reviewed by the inspectors the last review documented in one set of care documentation stated the assessment had last been reviewed on 29/6/11, another patients risk assessment stated that the last review had been in July 2014 and the third patients risk assessment reviewed by the inspectors stated it had been reviewed on 18/9/14. Assessments reviewed by the inspectors were detailed and comprehensive however there was no evidence of involvement from patients, carers/relatives or advocates in the completion of the assessment. A recommendation has been made in relation to this	Moving towards Compliance

A new multi-disciplinary meeting template (MDT) had been introduced onto the ward to record who attends the meeting, the discussions that have taken place and planned action points. However, the inspectors reviewed three set of care documentation and there was inconsistent records completed for patients. There was no evidence in some of the records of what had been discussed and agreed at the meeting. Therefore it was unclear what plans had been agreed for the patients. In the three sets of care documentation reviewed by the inspectors there was no record of patients, relatives/carers involvement in meetings and no indication of the reason why they did not attend. In one set of care documentation reviewed by the inspectors there was evidence that the patient's views had been sought prior to one of the multi-disciplinary meeting and there was evidence that staff had met with this patient after the meeting to discuss the outcome. However this was inconsistent and did not happen each week. There was no evidence in two of the three sets of care documentation that patients or their relatives/carer had been involved in the multi-disciplinary meetings. A recommendation has been made in relation to this Inspectors spoke to one relative who advised they were updated regularly on their relative's progress when they visit the ward. The relative stated that the care on the ward was "brilliant" and they were "100 % happy" with their relatives care. They stated they could ring anytime to get an update on their relative's progress. It was good to note that in the three sets of care documentation reviewed by the inspectors there was evidence that care plans were individualised and person centred with reference made to human rights article 8. Out of the three sets of care documentation there was evidence in two sets that patients and relatives had been involved in completing care plans. In one patient's care plan there was no evidence of involvement from patients or carers/relatives. A recommendation has been made in relation to this. It was clear from information in the patients' care documentation that two patients had issues in relation to sensory problems however there was no evidence of a sensory assessment been completed for these patients. A recommendation has been made in relation to this Two of the three sets of care documentation reviewed by the inspectors indicated that patients had problems in relation to their communication needs. However, there was no evidence of speech and language therapy involvement with these patients in relation to setting up communication aids/tools. In one set of care documentation it stated in the patient's care plan to 'adhere to speech and language recommendations re: communication'. However there was no evidence in the file of a speech and language assessment been completed or what the recommendations were. A recommendation has been made in relation to this In the three sets of care documentation there was no evidence that individualised assessments had been completed for patients in relation to therapeutic and recreational activities. A recommendation has been made	

in relation to this.	

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:	
Following Admission, all patients are assessed by the ward based Occupational Therapist and individualised recreational/therapeutic programmed devised taking into consideration the patient's needs, likes/dislikes and Risk Assessments. Activities provided are individual and group work. A range of activities are available at ward level such as cookery, self-care, cleaning, music and art .Patients are facilitated to access areas outside the ward e.g. going for walks, going to the local shop and some patients also go out on a regular basis with their families, e.g. shopping and home leave. Staff/patient meeting are held and patients are encouraged to make suggestions and exercise their choice to influence the activities available. A number of patients attend Community Day Care/ Day time opportunities Monday - Friday. Respect for private and family like is paramount and family/carers are facilitated to visit their relative during their stay in hospital. (Article 8)	Compliant
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
Inspectors completed a direct observation of the ward over the two day inspection period. The inspectors were concerned to note there was no evidence of therapeutic activities taking place for patients on the ward. Patients were observed lying in their beds, walking aimlessly around the ward and garden area. Patients were observed shouting at each other with staff having to intervene. The inspectors observed only one patient taking part in an activity with a member of staff on the ward. Inspectors were advised that two patients attend day care. However there was no evidence of therapeutic or recreational activities in place for the other eight	Not compliant

patients on the ward. There were no recreational and therapeutic assessments completed for individual patients to guide staff in carrying out activities. The occupational therapist had not been on the ward since 19/8/14. Inspectors noted that staff were not actively engaging with the patients; communication was basic and they did not seem to be encouraging patients to take part in activities. Staff were observed completing enhanced observations with patients. They did not use this opportunity to engage meaningfully with the patient. One staff member was observed sitting reading a magazine and ignoring the patient. However when another staff member took over they were observing chatting to the patient and involving them in conversation. Three of the four professionals that spoke to the inspectors raised concerns regarding the lack of activities on the ward for patients. Recommendations have been made in relation to this. One patient was observed being monitored with enhanced observation by two members of staff in their bedroom. The inspectors observed very little activity been completed with this patient even though there was a psychology and behavioural assessment completed which stated this patient should be involved in pro-active strategies. These strategies included, " listening to music, dancing to music, singing songs, going out on the bus, doing puzzles, beading, lego, painting, watching TV. It stated the patient should be following a "comprehensive structured activity plan" however over the two days of the inspection there was no evidence of any of these activities being carried out with this patient. Recommendations have been made in relation to this. Inspectors spoke to one family member who raised concerns regarding the lack of stimulation on the ward for their relative. They advised that they had found it difficult to get staff to embrace previously successful interventions. They felt there was a resistance to other staff from the community visiting their relative on the ward to assist in implementing interventions. They advised they had offered to show staff how to work with their relative but this was declined. They were very concerned about their relative been bored on the ward which increased their level of frustration, leading to increased episode of challenging behaviour. A recommendation has been made in relation to this There was evidence of a considerable increase in the use of seclusion on the ward. There had been no episodes in July 2014, one episode in August and nine episodes in September involving three patients. The use of the low stimulus environment had also increased from six episodes in July involving two patients, two episodes in August involving one patient and 21 episodes in September involving four patients. The use of restraint had also increased with nine episodes in July involving two patients, 17 in August involving two patients, and 30 episodes in September involving four patients. There had been five staff assaulted on the ward over the past two months by patients and they were now on sick leave. This had resulted in increased levels of banking staff on the ward.	

The inspectors were concerned to note the increased level of restrictive practices on the ward and the increased levels of challenging behaviours. The inspectors were advised by the nurse in charge that the clinical director is aware of the current situation in the ward and an action has been agreed in relation to the above issues. Recommendations have been made in relation to this . There was evidence in the nursing notes that patients article 8 rights to respect for private and family life had been considered.	

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:	
All patients on admission receive a full explanation about their human right in a format suitable to the individuals need. Staff continue to reinforce this information throughout the admission. Easy read version of Human Rights and Mental Health Order (N.I.1986) is available to meet the individuals need. Speech and Language Therapy is also utilised to support the patient in understanding their Human Rights. Independent patient advocate will also facilitate patient/family carers in relation to information on their rights. The Advocate is invited to the ward weekly meetings and contact details are displayed throughout the ward .Patients who need assistance are facilitated to contact the advocate on request. Patient choice in relation to the right to refuse care and treatment, and the Mental Health Order NI1986 is respected, and is explained to patients with use of easy read version as above. Nursing staff ensure patients' rights are read and leaflet given to patient on each occasion of progression of the detention process or change in status and patient/staff sign accordingly. The patient's Right to Liberty and Security of person is adhered to at all times. Any deprivation of liberty deemed necessary, must be proportionate to the risk identified and should not be for longer than necessary. (Article 5) Any deprivation of liberty has a clear plan of care and is agreed by the Multi-Disciplinary Team at the weekly ward meetings. Respect for private and family life is paramount and families/carers are facilitated to visit their relative during their stay in	Compliant

hospital. (Article 8)	
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
It was good to note that easy read information was available on the ward for patients in relation to the advocacy service, patients rights when in hospital which included their human rights in relation to articles 3, 5 ,8 and 14. There was also information on the locked door, the low stimulus suite, managing aggressive behaviours and how to make a complaint Inspectors were informed by the nurse in charge of the ward that there were five patients on the ward who were detained in accordance with the Mental Health (Northern Ireland) Order 1986. It was good to note there was easy read information available on the ward for these patients in relation to their rights under the Mental Health (Northern Ireland) Order 1986. This included information on the detention process, treatment plans, how to complain about your detention and how to apply to the Mental Health Review Tribunal Information was displayed in the ward notice board on how to make a complaint and how to access the independent advocacy service. This was also in easy read format. The ward has access to an advocate who meets with all patients on the ward to provide support. When inspectors spoke to three patients on the ward they were all aware of the advocacy service. One patient stated that the advocate had attended meetings with them to support them in finding a suitable placement in the community.	Compliant

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**
All individuals are assessed on admission, and there are no blanket restrictions or deprivation of liberty. Each patient is individually risk assessed, and any Restrictive Interventions deemed necessary must have a clear rational for use and agreed by the Multi-Disciplinary Team and reviewed weekly. Any Restrictive Intervention used is discussed with patient/family carer and is the least restrictive practice and is proportionate to the level of assessed risk, and is used for the minimum length of time. Patient agreement is sought and evidenced where possible by patient signature All Dorsy Unit staff have attended Restrictive Intervention awareness sessions. All staff working in the Dorsy Unit are MAPA Level 4 trained. All restrictive practices are reviewed weekly and audited monthly. Independent Patient Advocate is available to support and advise patient/family carer in relation to Restrictive practices.	Compliant

All patients are treated individually with dignity and respect, have a Personal Centred Plan and are free from torture, inhuman or degrading treatment (Article 3). The patient's Right to Liberty and Security of Person is adhered to at all times (Article 5). All patients are treated equally and free from discrimination. (Article 14) .	
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
All three sets of care documentation reviewed by the Inspectors indicated that the patients were detained in accordance with the Mental Health (Northern Ireland) Order 1986. It was good to note that individual care plans had been developed in relation to this process. These detailed the importance of giving patients information on the detention process in an appropriate easy read format, having discussions with patients around the detention process and making sure patients have access to the advocacy service on the ward. Inspectors noted in the three sets of care documentation that individualised care plans were in place for all three patients in relation to restrictive practices. A number of care plans detailed a clear rationale around the restriction in place in relation to for example; the locked door on the ward, enhanced observations and patients clothing having to be removed from their rooms. However there were care plans in place which did not have a clear rationale. One care plan stated 'X may require MAPA to effectively manage the level of risk she poses to herself and others in the environment'. There was no detail of the actual risk the patient posed. Another care plan stated 'X may be unable to maintain his safety' and there was no explanation around this statement. There was evidence in two of the three sets of care documentation that patients and their relatives had been involved in completing care plans. There was no evidence in one set of care documentation that patients or their relatives/carers had been involved in the patient's care plan. There was no evidence in the three sets of care documentation that care plans were reviewed regularly by staff on the ward. Recommendations have been restated in relation to this There was reference throughout the care plans reviewed by the inspectors that staff had considered the potential impact of restrictive practice on the patients human rights in relation to articles 3, 5, 8 and 14 It was good to note that out of the 12 questionnaires which were completed by staff prior to the inspection, 11 staff members indicated that they had received training in relation to restrictive practice.	Moving toward compliance

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:	
All patient/family carers are invited to participate in Discharge Planning Meetings at the earliest opportunity which are multi-disciplinary and involve the Independent Patient Advocate. Patients are discharged to home or community setting supported by the Community Learning Disability team and Home Treatment/Crisis Response Team and Behavioural Support Team. On occasions when a patient is deemed medically fit for discharge a delay may occur until an appropriate and suitable placement is secured to meet that patient's specific needs. This information is forwarded to the Health and Social Care Board. Respect for private and family life is paramount and family/carers are facilitated to visit their relative during their stay in hospital. (Article 8)	Substantially Compliant
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
The nurse in charge advised that there were four patients on the ward who were delayed in their discharged from hospital. All four patients are waiting on placements in the community. Inspectors reviewed three sets of care documentation and noted patients did not have a nursing discharge care plan completed and there was no record of discharge planning meetings having been held therefore inspectors could not identify who was responsible for co-ordinating and progressing patient discharge from hospital. The inspectors spoke to one relative who stated that a discharge planning meeting had been arranged for their	Not compliant

relative. However in the care documentation there was no evidence of a discharge plan for this patient. Notes relating to patients discharge plans were recorded in the multi-disciplinary case conference record. However this was inconsistent throughout the three sets of care documentation reviewed by the inspector. There was no evidence that relative/carers or patients had attended these meetings or a reason why they did not attend. Recommendation have been made in relation to this Inspector spoke to a relative of one of the patients on the ward whose discharge was classed as delayed as there had been difficulties finding a suitable placement for this patient in the community. This relative stated they felt there was a lack of collaborating with community based professionals to assist in the discharge arrangement for her relative. They felt it was left up to then to source a suitable placement in the community. When inspectors spoke to members of staff regarding discharge planning staff stated that patients were waiting for suitable placement in the community and they recognised there was very little focus on the discharge plans for these patients, as there were problems finding suitable placement. Recommendations have been made in relation to this. The nurse in charge ward confirmed that the Health and Social Care Board are informed of delayed discharges.	

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

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