The Regulation and Quality Improvement Authority

Dorsy Assessment and Treatment Unit

Craigavon Area Hospital

Southern HSC Trust

Unannounced Inspection Report

Date of inspection: 24 June 2015

npm national preventive mechanism

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Our Vision, Purpose and Values

Vision

To be a driving force for improvement in the quality of health and social care in Northern Ireland

Purpose

The Regulation and Quality Improvement Authority (RQIA) is the independent health and social care regulator in Northern Ireland. We provide assurance about the quality of care, challenge poor practice, promote improvement, safeguard the rights of service users and inform the public through the publication of our reports.

Values

RQIA has a shared set of values that define our culture, and capture what we do when we are at our best:

- **Independence** - upholding our independence as a regulator
- **Inclusiveness** - promoting public involvement and building effective partnerships - internally and externally
- **Integrity** - being honest, open, fair and transparent in all our dealings with our stakeholders
- **Accountability** - being accountable and taking responsibility for our actions
- **Professionalism** - providing professional, effective and efficient services in all aspects of our work - internally and externally
- **Effectiveness** - being an effective and progressive regulator - forward-facing, outward-looking and constantly seeking to develop and improve our services

This comes together in RQIA's Culture Charter, which sets out the behaviours that are expected when employees are living our values in their everyday work.

Contents

1.0 Introduction

The Regulation and Quality Improvement Authority (RQIA) is the independent health and social care regulator in Northern Ireland. We provide assurance about the quality of care, challenge poor practice, promote improvement, safeguard the rights of service users and inform the public through the publication of our reports.

RQIA's programmes of inspection, review and monitoring of mental health legislation focus on three specific and important questions:

Is Care Safe?

- Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them

Is Care Effective?

- The right care, at the right time in the right place with the best outcome

Is Care Compassionate?

- Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support

2.0 Purpose and Aim of this Inspection

To review the ward's progress in relation to recommendations made following previous inspections.

To meet with patients to discuss their views about their care, treatment and experiences.

To assess that the ward physical environment is fit for purpose and delivers a relaxed, comfortable, safe and predictable environment.

To evaluate the type and quality of communication, interaction and care practice during a direct observation using a Quality of interaction Schedule (QUIS).

2.1 What happens on inspection

What did the inspector do:

- reviewed the quality improvement plan sent to RQIA by the Trust following the last inspection(s)

- talked to patients, carers and staff
- observed staff practice on the days of the inspection
- looked at different types of documentation

At the end of the inspection the inspector:

- discussed the inspection findings with staff
- agreed any improvements that are required

After the inspection the ward staff will:

- send an improvement plan to RQIA to describe the actions they will take to make any necessary improvements

3.0 About the ward

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. On the day of the inspection there were six patients on the ward and three of these patients 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, a doctor, a behaviour nurse therapist, a psychologist (two mornings a week) an occupational therapist and a social worker. An independent advocacy service from disability action is also available for patients on the ward.

On the day of the inspection there were two patients on enhanced observation. One patient had 2:1 observations in place and one patient had 1:1 observations in place. There were two patients on the ward whose discharge was delayed. The ward manager was in charge on the day of the inspection.

4.0 Summary

Progress in implementing the recommendations made following the previous inspections carried out on 21 and 22 October 2013 and 4 and 5 November 2014 were assessed during this inspection. There were a total of 24 recommendations made following the last inspection four of these had been stated for the first time following the inspection undertaken on 21 and 22 October 2013.

It was good to note that 19 recommendations had been implemented in full.

One recommendation had been partially and four recommendations had not been met. These recommendations will be restated for a **second** time following this inspection.

The inspector was pleased to note that comprehensive risk assessments (CRA) had been reviewed regularly and completed with the involvement of patients and when appropriate carers/relatives. The ward had a fulltime occupational therapist who had completed individual therapeutic/recreational timetables for patients. Assessments were completed for patients with sensory problems and communication difficulties. Patients and their carers/relatives had been given an opportunity to be involved in completing care plans and individualised recreational/therapeutic activity timetables. Staff were providing patients with enhanced observation but were also attending to patients' individual needs. Patients had access to psychology, occupational therapy, behaviour support and speech and language therapy. Care plans were in place in relation to the deprivation of liberty experienced by patients and detailed the rationale around each restriction. These were reviewed regularly to ensure the least restrictive option was in place. Throughout the day of the inspection staff were observed bringing patients out to various places in the community and patients appeared to be receiving appropriate levels of care and attention to meet their needs.

The inspectors assessed the ward's physical environment using a ward observational tool and check list. The environment appeared relaxed, comfortable, clean and clutter free. There was easy read information displayed throughout the ward. Rooms were available for patients to have quiet time on their own and there was areas in the main part of the ward for patients to spend time in the company of others. All patients had their own private bedroom with ensuite. The ward had access to a number of garden areas which were well maintained and available for patients to access freely throughout the day. However one of the gardens did not have a seating area for patients. This was discussed with the ward manager who advised that they had ordered seats for this garden. The inspectors observed the wards therapy room to be very small and lacked appropriate tables to support therapeutic activity. A recommendation has been made in relation to this.

During the inspection the inspectors completed a direct observation using the Quality of Interaction Schedule (QUIS) tool. This assessment rated the quality of the interactions and communication that took place on the ward between patients, nursing staff and ward professionals. Overall the quality of interactions between staff and patients were positive.

During the inspection the inspectors spoke to three patients who had agreed to meet with them to complete a patient experience questionnaire. This recorded their experience in relation to the care and treatment they had received on the ward. All three patients made positive comments about how they had been treated on the ward.

Other inspection findings

The inspectors reviewed three sets of care documentation and there was evidence that care plans were inconsistently reviewed by staff on the ward. Staff were recording this information in the progress notes and in a 'nursing

care evaluation' form. A new recommendation has been made in relation to this

A new recommendation has also been made in relation to the completion of risk screening tools as these were inconsistently completed with sections left blank. There was no indication if a CRA was required and no signature of the patient or carer/relative and no indication why these had not been signed.

4.1 Implementation of Recommendations

Two recommendations which relate to the key question "**Is Care Safe**?" were made following the inspection undertaken on 4 and 5 November 2014.

These recommendations concerned how comprehensive risk assessments had been completed as they had not been completed in accordance with the Promoting Quality Care Guidance Document. A recommendation had also been made in relation to reviewing the purpose and function of the ward due to the complexity and variety of patients on the ward.

The inspector was pleased to note that these two recommendations had been fully implemented.

- Comprehensive risk assessments (CRA) had been reviewed regularly with the involvement of patients and when appropriate carers/relatives.
- The Trust have reivewed the purpose and function of the ward and had updated the 'Operational Guidelines for Dorsy Assessment and Treatment Unit". The Trust had also completed a Telford review of staff and recruited new staff members to the ward.

18 recommendations which relate to the key question "**Is Care Effective**?" were made following the inspections undertaken on 21 and 22 October 2013 and, 4 and 5 November 2014. Two of these had been stated for the first time following the inspection undertaken on 21 and 22 October 2013.

These recommendations concerned the absence of an occupational therapist on the ward and patients did not have an individual therapeutic/recreational timetable in place. There was inconsistent recording of information relating to patients by all disciplines and there was no evidence that patients' capacity to consent to care and treatment was being monitored. When patients lacked capacity in this area there was no evidence that 'best interest' meetings had been held and where appropriate patients carers/advocates were involved in these meeting and formal assessments.

Records relating to the multidisciplinary team (MDT) meetings had been inconsistently completed and patients who had been assessed as requiring support in relation to their communication and sensory needs did not have these assessments completed. Recommendations were made in relation to patients and relatives being involved in completing care plans as this had not

taken place. When staff were completed enhanced observations they were not meeting patients individual needs as well as managing risk. Concerns had been raised in relation to how staff work with patients' families to ensure patients are fully supported in relation to therapeutic interventions. In relation to discharge planning there was no evidence of discharge planning meetings having been held and patients did not have a nursing discharge care plan completed. One patient raised concerns regarding locking their bedroom door and a member of the MDT team raised concerns regarding patient's access to physical health care screening.

The inspector was pleased to note that 13 recommendations had been fully implemented.

- The ward had a fulltime occupation therapist who had completed individual therapeutic/recreational timetables for patients.
- All members so the MDT team were recording information in the patients care documentation.
- Staff were reviewing patients consent to care and treatment on a daily basis and this was recorded in the patients progress notes.
- Assessments were completed for patients with sensory problems and communication difficulties.
- Patients and their carers/relatives had been given an opportunity to be involved in completing care plans and individualised recreational/therapeutic activity timetables.
- Staff were observed completing enhanced observations and attending to patients' individual needs. Records of these activities were recorded in the patients' progress notes.
- Patients had access to psychology, occupational therapy, behaviour support and speech and language therapy.
- Patients could ask a member of staff to lock their bedroom door. None of the patients who spoke to the inspectors raised concerns regarding locking their bedroom door.
- The Trust had reviewed the purpose and function of the ward and had updated the 'Operational Guidelines for Dorsy Assessment and Treatment Unit'.
- The ward manager had made arrangements with the health care facilitators to discuss physical health care screening for patients.

However, despite assurances from the Trust, five recommendations had not been fully implemented. It was unclear how patient's capacity to consent to care and treatment was being monitored by the MDT team. In relation to one patient who was assessed as lacking capacity there was evidence that a best interest meeting had been held, however the minutes of this meeting were not completed in full and therefore did not detail the outcome of the meeting or

what had been discussed. There was no evidence that patients relatives and carer were involved in meetings regarding patients capacity to consent. Records of MDT meetings were inconsistently completed each week. In relation to discharge planning there was no evidence of discharge planning meetings having been held. A senior Trust representative stated that meetings are held each month however, they were not able to access the minutes of these meetings. Patients did not have a nursing discharge care plan completed.

Four recommendations which relate to the key question "**Is Care Compassionate**?" were made following the inspections undertaken on 21 and 22 October 2013 and, 4 and 5 November 2014. Two of these had been stated for the first time following the inspection undertaken on 21 and 22 October 2013.

These recommendations concerned care plans in relation to deprivation of liberty as they did not detail a clear rationale around the restriction in place for each patient. There was no evidence that these were reviewed regularly to ensure the least restrictive option was in place. The inspectors were concerned that when the alarm was raised it is very loud and appeared to upset a number of patients on the ward especially patients with sensory problems.

The inspector was pleased to note that all four recommendations had been fully implemented.

- Care plans were in place in relation to the deprivation of liberty experienced by patients. These were individualised and detailed the rationale around each restriction.
- Care plans in relation to restrictive practices were reviewed regularly at the MDT meeting each week to ensure the least restrictive option was in place.
- The alarm system had been turned down and none of the patients raised any concerns regarding the alarm when they spoke to the inspectors.

The detailed findings from the follow up of previous recommendations are included in Appendix 1.

5.0 Ward Environment

"A physical environment that is fit for purpose delivering a relaxed, comfortable, safe and predictable environment is essential to patient recovery and can be fostered through physical surroundings." Do the right thing: How to judge a good ward. (Ten standards for adult-in-patient mental health care RCPSYCH June 2011)

The inspector assessed the ward's physical environment using a ward observational tool and check list.

Summary

The ward's main reception area and lounge areas were well presented and included notice boards that displayed information detailing the ward's philosophy, staffing, activities and advocacy service. The ward's patient information booklet was presented to a high standard it was good to note that this was available in easy read format.

There was information displayed on the ward's main notice board in relation to the date, time and day, the Trust's complaints procedure, the adult safeguarding procedures and an RQIA easy read inspection report. It was positive to note that the ward provided a large amount of easy read information available for patients. This included information in relation to Human Rights, the Mental Health (Northern Ireland) Order 1986, The Mental Health Review Tribunal and patients' right to access information held about them.

The ward's environment presented as clean, clutter free and well maintained. There was good ventilation, large lounge areas and neutral odours. Ward furnishings were well maintained, comfortable and appropriate to the needs of the patient group. Patients could access three garden areas which were noted to be appropriately maintained and easy to access. The garden area located on the east side of the ward required seating. The ward manager informed inspectors that seating had been ordered and would be available in the near future.

Patients' had their own ensuite bedrooms located within easy access to the ward's lounge, kitchen and the dining area. Inspectors observed that patient access throughout the ward was appropriate and patients could go outside or return to their bedrooms as required. The ward was equipped with appropriate signage to help orientate patients. Patients could also access the support of the ward's Occupational Therapist on a daily basis Monday to Friday. However the therapy room was observed to be very small and lacked appropriate tables to support therapeutic activity. A recommendation has been made in relation to this.

The room used to facilitate visits from patients' relatives' carers was located opposite the ward's main office. The room was bright, appropriately furnished and well maintained. Inspectors noted that ward staff were available throughout the ward and patients presented as relaxed and at ease in their surroundings.

Two patients admitted to the ward were receiving enhanced observations. Staff members providing this level of support throughout the day were observed engaging with patients and treating them with respect and dignity.

Staff demonstrated a high level of knowledge and skill in supporting patients receiving enhanced observations. It was good to note that staff had successfully reduced one patients need to access the enhanced care suite despite the patient continuing to present with behaviours that challenged.

Inspectors reviewed the ward's enhanced care suite and noted that it was managed in accordance to Trust and regional policy and procedure.

The detailed findings from the ward environment observation are included in Appendix 3.

6.0 Observation Session

Effective and therapeutic communication and behaviour is a vitally important component of dignified care. The Quality of Interaction Schedule (QUIS) is a method of systematically observing and recording interactions whilst remaining a non- participant. It aims to help evaluate the type of communication and the quality of communication that takes place on the ward between patients, staff, and visitors.

The inspector completed direct observations using the QUIS tool during the inspection and assessed whether the quality of the interaction and communication was positive, basic, neutral, or negative.

Positive social (PS) - care and interaction over and beyond the basic care task demonstrating patient centred empathy, support, explanation and socialisation

Basic Care (BC) – care task carried out adequately but without elements of psychological support. It is the conversation necessary to get the job done.

Neutral – brief indifferent interactions

Negative – communication which is disregarding the patient's dignity and respect.

Summary

The formal session involved observations of interactions between staff and patients/visitors. Three interactions were observed and the outcome of these interactions were as follows:

Positive	Basic	Neutral	Negative
100%	0%	0%	0%

Patients on the ward appeared relaxed and at ease in their surroundings. The staff appeared to have a good level of understanding in relation to each

patient's individual needs. Patients moved freely throughout the ward and there were a number of activities available including a music session, walk and occupational therapy sessions.

Inspectors observed interactions between staff and patients throughout the day of the inspection. Staff were noted to be positive and respectful during their interactions with patients. Staff engaged with patients using appropriate verbal and non-verbal communication and inspectors evidenced that staff understood patient needs and responded quickly to patient requests. Inspectors witnessed staff to be attentive, observant and supportive towards patients.

The detailed findings from the observation session are included in Appendix 4

7.0 Patient Experience Interviews

Three patients agreed to meet with inspectors to talk about their care, treatment and experience as a patient. Each of the patients agreed to complete a questionnaire regarding their care, treatment and experience as a patient.

- Patients who met with inspectors stated that they felt staff were helpful and easy to talk to.
- Patients reported no concerns regarding their care and treatment.
- Patients stated that they felt safe on the ward and they were involved in decisions regarding their treatment and care. One patient described an experience when he did not feel safe on the ward. The patient explained that staff had helped them to feel better and to manage their fears.
- Patients stated that they had been informed of their rights upon admission.
- Patients informed inspectors that they felt they had been treated with dignity and respect.
- Patients explained that they had been involved in their care and treatment plans. They advised that staff sought their consent prior to supporting them.
- Patients reflected that they felt they had been listened to and their views had been taken on board.

Patient's comments included:

"Staff have plenty of time for you";

"Foods good";

"xxxx is my named nurse";

"Everything is good".

The detailed findings are included in Appendix 2

8.0 Other areas examined

During the course of the inspection the inspector met with:

Ward Staff	**2**
Other ward professionals	**2**
Advocates	**0**

Wards staff

The inspectors met with two members of nursing staff on the day of inspection. Staff who met with the inspectors did not express any concerns regarding the ward or patients' care and treatment. There both expressed positive changes having been made on the ward and valued the input of the occupational therapist.

Other ward professionals

The inspectors met with the behaviour nurse specialist for the ward. They provided the inspectors with a summary of their role. They explained the variety of work they undertake with patients on the ward. The behaviour nurse did not express any concerns regarding the ward or patients' care and treatment.

The inspectors met with the occupational therapist for the ward. They provided the inspectors with a summary of their role. They explained the variety of work they undertake with patients on the ward and how they hold a therapeutic meeting each week with the psychologist, behaviour support nurse, social worker and nursing staff to discuss and plan therapies for patients on the ward. The occupational therapist did not express any concerns regarding the ward or patients' care and treatment.

The advocate

The inspection was unannounced. No advocates were available to meet with the inspectors during the inspection.

9.0 Next Steps

A Quality Improvement Plan (QIP) which details the areas identified for improvement has been sent to the ward. The Trust, in conjunction with ward staff, must complete the QIP detailing the actions to be taken to address the areas identified and return the QIP to RQIA by 11 August 2015

The lead inspector will review the QIP. When the lead inspector is satisfied with actions detailed in the QIP it will be published alongside the inspection report on the RQIA website.

The progress made by the ward in implementing the agreed actions will be evaluated at a future inspection.

Appendix 1 – Follow up on Previous Recommendations

Appendix 2 – Patient Experience Interview
This document can be made available on request

Appendix 3 – Ward Environment Observation
This document can be made available on request

Appendix 4 – QUIS
This document can be made available on request

Appendix 1

Follow-up on recommendations made following the unannounced inspection on 4 and 5 November 2014.

No.	Reference.	Recommendations	No if times stated	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
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	The inspectors reviewed three sets of care documentation and there was evidence that patients had deprivation of liberty care plans in place. Each care plan detailed the rationale for the level of restriction in terms of necessity and proportionality. Care plans were signed by patients or their carer/relatives.	Fully met
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	The ward had reviewed restrictive practices which included the locked door to the unit. Patients' restrictive practice care plans detailed the rationale for the level of restriction in terms of necessity and proportionality. Care plans were reviewed at the MDT meetings each week to ensure that the least restrictive practice was in place to ensure of patients' safety and wellbeing. However the inspectors noted that staff were documenting that they had reviewed care plans in a number of different sections in the care document. Therefore the approach to reviewing care plans was not consistent throughout the care documentation. Staff were recording the outcome of the care plans reviewed in the progress notes and in a 'nursing care evaluation form'. A new recommendation has been made in relation to this.	Fully met
3	5.3.1. (a)	It is recommended that the Trust ensure that occupational therapy is	2	The inspectors spoke to the occupational therapist (OT) on the ward who advised that they work fulltime from Monday to Friday each week. The inspectors reviewed three sets of	Fully met

		made available to all patients in the assessment and treatment unit		care documentation and there was evidence that the OT had completed an OT priority checklist for each patient. Assessments had been completed in relation to areas such as road safety skills, activities of daily living and functional skills. The OT had also completed sensory integration reports and developed sensory strategies for a number of patients who were assessed as requiring these assessments.	
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	The inspectors reviewed three sets of care documentation and there was evidence that disciplines had recorded all aspects of care provided to patients in the care documentation to ensure that there was a continuous record of patients care and treatment.	Fully met
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	In all three records reviewed by the inspectors there was evidence that care plans in relation to actual or perceived deprivation of liberty were reviewed. These care plans included a rationale based on the individual risks to the patient to ensure the deprivation of liberty was proportionate and necessary.	Fully met
6	5.3.1 (f)	It is recommended the multi-disciplinary team ensures that all patients have a capacity	1	The inspectors reviewed three sets of care documentation and there was evidence that concerns had been raised by the multidisciplinary team regarding one patients' capacity to understand their care and treatment. However there was no	Not met

		assessment completed and that this is monitored and re-evaluated regularly by the multi-disciplinary team throughout the patient's admission to hospital.		evidence that this patient had a capacity assessment completed. There was no evidence that patients' capacity was monitored and re-evaluated regularly by the multi-disciplinary team. The MDT template had a section to record if patients' capacity had 'changed'. However this manner of recording was very unclear as it did not indicate the specific area of capacity that had been assessed. This recommendation will be restated for a second time.	
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	In the three sets of care documentation reviewed there was evidence that a best interest meeting had been held in respect of one patient who had been deemed as lacking capacity in relation to their care and treatment. However the minutes of this meeting had not been completed in full with regard to who attended, what was discussed and the outcome. When this was discussed with the ward manager they were unsure of the outcome of this meeting. This recommendation will be restated for a second time	Not met
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 documentation.	1	There was no evidence in the care documentation reviewed that a formal capacity assessment had been completed with patients and their relatives/ carers when concerns had been raised in relation to patients' capacity. The inspectors reviewed one set of care record and there was evidence that a best interest meeting had been held. However the minutes of this meeting did not detail a full account of the meeting. They had not been completed in full with regard to who attended the meeting, what was discussed and the outcome. This recommendation will be restated for a second time	Not met
9	5.3.1 (f)	It is recommended that the	1	The inspectors were advised by the ward manager that	Fully met

		ward sister ensures that staff assess patients consent to daily care and treatment and that this is recorded in the patients continuous nursing notes		patients' capacity to consent to care and treatment was monitored and evaluated by staff on a continuous basis. This was evidenced in the patients' progress notes.	
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	In the three sets of care documentation reviewed there was evidence that patients and their carers/relative where appropriate had been involved in completing comprehensive risk assessments. The assessments had been reviewed on a regular basis 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 However in the three sets of care documentation reviewed the risk screening tools had not been completed in full. Sections were missing in relation to who had contributed to the assessment and there was no indication of the further action required. A new recommendation will be made in relation to this	Fully met
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	1	The inspectors reviewed three sets of care documentation and the multidisciplinary team (MDT) template had been completed in full in a number of records. However this was inconsistent as there were also a number of MDT records that had not been completed in full. In a number of records there was no indication if patients had attended the meeting	Partially met

		attended the reasons why are clearly documented.		and if they had not attended a reason had not been recorded. This recommendation will be restated for a second time.	
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	The inspectors reviewed three sets of care documentation and there was evidence that comprehensive care plans, nursing assessments and comprehensive risk assessments had been completed by the community team prior to the patients being admitted onto the ward. There was evidence that care plans were devised from these assessments. There was evidence that patients had sensory assessments completed by the occupational therapist when this was required.	Fully met
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	There was evidence in the three sets of care documentation reviewed that patients who had been assessed as having communication needs had been referred to the speech and language therapist. Communication assessments had been completed with recommendations and strategies to be implemented**.**	Fully met
14	5.3.3 (b)	It is recommended that the ward sister ensure that all patients and 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.	1	There was evidence in the three sets of care documentation reviewed that patients and where appropriate relatives had been involved in completing care plans. If they have not been involved the reasons why were documented.	Fully met
15	5.3.1 (a)	It is recommended that the ward sister ensures that patients have individualised	1	In the three sets of care documentation reviewed there was evidence that patients had individualised assessments completed for therapeutic and recreational activities and a timetable had been set up for each patient. These were in	Fully met

		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.		pictorial format and were displayed in the patients' bedrooms if they agreed to this arrangement. A record was maintained of the patients' participation and progress in relation to these activities. The occupational therapist also held therapeutic meetings each week with the psychologist, behaviour support nurse, social worker and nursing staff to discuss and plan therapies/goals for patients on the ward.	
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 but also meet each patient's individual needs and that this is documented.	1	Staff members who were carrying out enhanced observations were observed by the inspectors managing risks but also meeting each patient's individual needs. They were completing activities with patients and this was clearly documented in the patients' progress notes.	Fully met
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	1	In the three sets of care records reviewed by the inspectors there was evidence that patients had access to a range of professionals with specialist skills. There was evidence that sensory assessments had been completed by the occupational therapist with strategies that should be put in place for each patient. Communication assessments had been completed by the speech and language therapist who had devised communication booklets and set up strategies to be implemented to assist patients' communication difficulties. The behaviour nurse therapist had also completed positive behaviour support plans for those patients who had been referred to this service. Patients also had access to psychology services two mornings per	Fully met

		plans		week.	
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	The inspector was informed by the ward manager that the Trust had recently completed a review of the staffing levels on all wards across the bluestone site (Telford Study). A project is currently in place to recruit three new staff to the ward. On the day of the inspection there were no concerns noted regard staffing levels for the ward. The ward now has a fulltime occupational therapist working on the ward from Monday to Friday each week.	Fully met
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	There was evidence in the three sets of care documentation reviewed that staff had worked with patients and their families/carers in relation to setting up therapeutic interventions. Patients had signed their care plans and occupational therapy consent forms. When patients had been unable to sign families/carers had signed care plans.	Fully met
20	8.3 (i)	It is recommended that the ward sister ensures that that staff collaborate with community based professionals so that a co-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	1	In the three sets of care documentation reviewed there was no evidence of discharge care plans having been developed for patients. There was no evidence of discharge planning meetings having been held even though two of the patients were delayed in their discharge. A senior Trust representative stated at the conclusion of the inspection that meetings had been held for these patients each month. The ward social worker attends the meetings; however there were no minutes recorded in the patients care documentation therefore there was no clear discharge plan in place which detailed progress and actions plans with timescales. As there were no minutes available it was	Not met

		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.		unclear if patients' family/carers had attended these meetings. This recommendation will be restated for a second time	
21	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	Patients can ask a staff member to lock their bedroom door and when they are in their bedrooms they can lock their own door. The patients who spoke with the inspector did not raise any concerns regarding locking their bedroom doors.	Fully met
22	4.3 (e)	It is recommended that the 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.	1	The Trust has reviewed the purpose and function of the ward and have updated the 'Operational Guidelines for Dorsy Assessment and Treatment Unit". There were six patients on the ward. Two of whom were delayed in their discharge as there had been some difficult finding suitable accommodation in the community. The ward also has a Learning Disability Crisis Response Service attached to the ward. The aim of this service is to support patients with complex learning disability needs to remain in the community. The service provides short-term assessment, support and treatment for adults with a learning disability	Fully met

				and their carers in an effort to avoid unnecessary admission to hospital.	
23	7.3 (k)	It is recommended that the ward sister ensures patients have access to physical health screening.	1	The ward sister has contacted the health care facilitators attached to the Southern Health and Social Care Trust who have agreed to complete physical healthcare assessments. Appropriate referrals can then be made by the senior house officer on the ward for patients to have access to physical health screening.	Fully met
24	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	The inspectors were advised by the ward sister that the noise level of the alarm system had been reduced on the ward. Patients who spoke with the inspector did not raise any concerns regarding the alarm system.	Fully met

R3

The Regulation and Quality Improvement Authority

Quality Improvement Plan

Unannounced Inspection

Dorsy Assessment and Treatment Unit, Craigavon Area Hospital

24 June 2015

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

The specific actions set out in the Quality Improvement Plan were discussed with the ward sister and the patient flow and bed management coordinator 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
Is Care Safe?					
1	5.3.3 (b)	It is recommended that the ward manager ensures that risk screening tools are completed in accordance with the Promoting Quality Care: Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability 2010	1	Immediate and ongoing	It has been communicated to the relevant disciplines the importance and requirement to ensure Promoting Quality Care Risk screening is completed. Baseline Audit conducted and the Ward Manager to monitor compliance. This will be audited monthly
2	5.3.1 (a)	It is recommended that the Trust reviews the availability of the call system for patients in the bathroom/toilet areas.	1	30 September 2015	The Call System in the Ensuite bathrooms and toilets were considered during the design phase in conjunction with HSCB Health Estates and it was considered that these were a potential ligature risk and could be tampered with leaving wiring exposed. Currently there are no alternatives on the market that would be robust enough. The majority of patients admitted to Dorsy are fully mobile and if any patient with additional needs is admitted the Nursing Assessment would take into consideration their individual needs in relation to additional assistance needed. Having reviewed this the position of the Trust remains the same.

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
Is Care Effective?					
3	5.3.1 (f)	It is recommended that the ward manager ensures that when nursing staff document that they have completed a review of the patients care plans that there is a consistent approach in how this is recorded.	1	Immediate and ongoing	To ensure a standardised approach is adapted when reviewing nursing careplans the Ward Sister has devised a Nuring Care Plan review template. This information has been diseminated to all Named Nurses.
4	5.3.1 (f)	It is recommended the multi-disciplinary team ensures that all 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.	2	31 August 2015	The decision to complete a Multi-disciplinary Capacity Assessment will be decided by the Multi-disciplinary Team on an individual basis.It is assumed that the patient has capacity unless it is otherwise demonstrated, this is in line with good practice guidelines. If capacity issues change this will be identified in the care plan and reviewed at the weekly MDT meeting ..
5	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	2	Immediate and ongoing	Good practice guidelines states that capacity is assumed unless that there are indications otherwise and the Trust adhere to this guidance. Where a patient is identified as lacking capacity then a best interest pathway is agreed, monitored and reviewed by the Multi-disciplinary Team.

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
		relation to decision making processes that are managed in accordance with DHSSPS guidance.			
6	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 documentation.	2	Immediate and ongoing	Relatives, Carers and Advocates will be involved in formal assessments in relation to capacity to consent and there will be clear documentation of this process in the patient record. The patient will be informed of this at all times. The Ward Sister will audit patient notes and monitor progress monthly .
7	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.	2	Immediate and ongoing	A clear record of who attends the Multi-disciplinary Team meeting will be maintained. If a patient, relative or carer has not attended the reasons why will be clearly documented. Ward Manager will monitor monthly compliance with this recommendation and liaise with the Multi-disciplinary Team.
8	8.3 (i)	It is recommended that the ward sister ensures that staff collaborate with community based professionals so that a co-ordinated multi-professional	2	Immediate and ongoing	A record of patient, relative /carers and community based professionals invitation, involvement in discharge planning meetings will be maintained. In the event of not being able to attend a record of how this information will be shared will be documented in patient records. The Multi-disciplinary

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
		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.			Team will revise the current Discharge Care Plan this will include progress, action plans and timescales. The patient Care Plan from admission is focused on meeting the needs of the individual to facilitate discharge. The Consultant, the Multi-disciplinary Team Relatives and Carers, Community Staff will be invited to input to this aim. This will be communicated to all involved.
9	5.3.1 (a)	It is recommended that the Trust reviews the use of the therapy room to ensure there is enough space for tables and chair so that therapeutic activities can be carried out.	1	30 September 2015	The Trust has reviewed the therapy rooms and whist nothing can be done structurally the ward team utilise all space available to facilitate therapeutic activity and where possible will access facilities off the ward i.e.resource centre and leisure facilities.

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
Is Care Compassionate?					
		No recommendation			

NAME OF WARD MANAGER COMPLETING QIP	Geraldine Dinsmore
NAME OF CHIEF EXECUTIVE / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Francis Rice

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

Inspector assessment of returned QIP		Yes	No	Inspector	Date
A.	Quality Improvement Plan response assessed by inspector as acceptable	X		AMcLellan	11/8/15
B.	Further information requested from provider				