Dorsy Ward

Assessment and Treatment

Address: Bluestone Unit, 68, Lurgan Road, Portadown BT63 5QQ

Dates of Inspection Visit: 26 – 28 July 2016

Names of Inspectors:

Wendy McGregor, Cairn Magill and Dr Brian Fleming

This report describes our judgement of the safety and quality of care in Dorsy ward. It is based on a combination of what we found when we inspected and from a review of all of the information available to the Regulation and Quality Improvement Authority (RQIA). This included information given to us from patients, the public and other organisations.

This inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in this service. The findings reported on are those that came to the attention of RQIA during the course of this inspection while assessing the four stakeholder outcomes under this year's theme of Patient Centred Care. The findings contained in this report do not exempt the Trust from their responsibilities in accordance with the Mental Health (Northern Ireland) Order 1986 and the Department of Health (DoH) standards. It is expected that the areas for improvement outlined in this report will provide the Trust with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

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1.0 Details of 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 days of the inspection there were nine patients on the ward; three patients were detained appropriately in accordance with the Mental Health (Northern Ireland) Order 1986.

The multi-disciplinary team consisted of nursing, psychiatry, medical occupational therapy, behaviour support and psychology. At the time of the inspection the occupational therapy, psychology and behaviour support service were based full time on the ward. An independent advocacy service was also available for patients on referral.

2.0 Inspection Summary

This inspection focused on the theme of Person Centred Care. This means that patients are treated as individuals, and the care and treatment provided to them is based around their specific needs and choices.

RQIA found the ward environment to be clean, comfortable and well maintained. The ward had an up to date health and safety assessment and ligature risk assessment completed. The fire risk assessment was one month out of date; however there was a plan in place to complete this on 10 August 2016.

Care was observed as compassionate on the ward. Patients and relatives spoke positively about their experience of Dorsy and were complimentary about all members of the multi-disciplinary team. Working relationships between the multi-disciplinary team were noted to be good. Staff demonstrated their commitment to the continuous improvement of the service and said they were well supported.

Patients had access to a range of therapeutic and recreational activities appropriate to their needs. An artist attends the ward every week.

There were appropriate governance mechanisms in place to review and analyse incidents and accidents. Good leadership and management of ward were evidenced.

Follow Up on Previous Inspection Recommendations

There were nine follow up recommendations made following previous inspections. All nine recommendations were implemented in full.

1. There was evidence of patient and relative involvement in the risk screening tools in accordance with the Promoting Quality Care: Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability 2010.

2. The trust had reviewed the availability of the call system for patients in the bathroom/toilet areas.

3. Nursing staff documented when they had completed a review of the patients care plans and used a consistent approach to record this.

4. The multi-disciplinary team had completed a capacity assessment when required and this was reviewed every week.

5. There were robust arrangements in place in relation to decision making processes when a patient was assessed as lacking capacity to consent. These arrangements complied with Department of Health, Social Services and Public Safety (2003) Seeking consent: Working with people with learning disabilities.

6. There was evidence that patients and/or their representatives were involved in formal assessments in relation to capacity to consent.

7. There was a clear record of attendance at the Multi-Disciplinary Team (MDT) meeting and if patient, relative/carers had not attended the reasons why are clearly documented.

8. Ward staff collaborated with community based professionals and a co-ordinated multi-professional discharge plan was in place. Care plans in relation to discharge planning were detailed and included progress and actions plans. Patients and relatives/carers were involved in discharge planning meetings where appropriate. A record was maintained if they were unable to attend. There was a record of how this information was shared with patients' relatives/carers. This was included in the patient's care documentation.

9. The Trust has reviewed the use of the therapy room. Tables and chairs were now in place for therapeutic activities.

3.0 How We Carried Out This Inspection

What the inspector(s) did:

- Reviewed a range of information relevant to the facility sent to RQIA before the inspection. This included policies and procedures, staffing levels, ward aims and objectives and governance protocols.
- Talked to patients, carers and staff.
- Observed staff working practices and interactions with patients on the days of the inspection.
- Reviewed other documentation on the days of the inspection. This included care records, incident reports, multi-disciplinary procedures and staff training records.
- Reviewed progress since the last inspection.

At the end of the inspection the inspector(s):

- Commended areas of good practice.
- Shared the inspection findings with staff.
- Highlighted areas for improvement.

4.0 What People Said About This Service

Patients Stated:

Inspectors met with five patients during the inspection. All patients spoke positively about their experience of Dorsy ward. Patients stated they felt safe on the ward. All five patients knew who their doctor and named nurse was and stated that their care was effective. Patients indicated that there were things to do to keep them busy and that being in hospital was helping them. All patients stated that the care they received was compassionate, and that staff were always available to talk to and they felt listened to.

Patients Said:

“I have good friends in here and the food is good but I would like more chips.”

“I get looked after very well.”

“It’s great here.”

“Absolutely brilliant.”

“Very kind and very decent people”

Relatives Stated:

Inspectors spoke with four relatives. All relatives were complimentary about the multi-disciplinary team. Relatives stated that staff were approachable, available and accessible. All relatives confirmed that they were involved in any decisions about their family members care and treatment. Relatives stated that they were kept fully informed of any accidents or incidents. Relatives stated that there was a noticeable improvement in the care and treatment on the ward in the past year and stated that they felt that the care and treatment their relative was receiving was beneficial. All relatives stated that their family member's privacy and dignity was respected.

Relatives Said:

"We are impressed by the environment."

"The ward is nice and bright."

"The nurses are lovely."

"I see an improvement in X since they have been here."

"I really appreciate that staff take X home for weekends and collect them."

"There's been a great improvement which reflects on X's behaviour. Their behaviour reflects how they are being cared for."

"There is nothing I could say that is wrong."

"It's a clean and tidy place. It's fabulous."

"I couldn't say a bad word about the place."

"Its lovely to get all the right people together."

"They treat X like they are one of their own."

"I am content that they are well look after."

Staff Stated:

Inspectors met with nine staff and two visiting professionals including a representative from the ward advocacy service. Staff were committed to the service and were enthusiastic about the care and treatment they delivered. Staff stated that the whole team worked very well together, that they considered that everyone was listened to and their views were respected. Staff all confirmed that they were well supported. Staff were complimentary about the ward manager, deputy ward manager and the hospital senior management team. All staff demonstrated a good knowledge on how to

support people with learning disabilities and people who require support with communication. Staff stated they have also noted improvements on the ward in relation to the reduction in the use of Pro Re Nata (PRN) medication.

Staff Said:

"I feel like I am making a difference."

"A patient who left last week said, I know I am leaving where staff really care."

"I want to be here because I know how valued you are here and the patients are valued."

"It is excellent here. I've never had a manager like the ward manager and deputy. I couldn't speak highly enough about them."

"There is excellent support from the hospital senior managers."

"I feel my voice is heard and I am valued."

"Nursing assistants have as much to say about introducing new things."

"It's very good. I am pleased to be here on placement. They are good at including you in the team."

"We can ring the consultants at any time. They are very approachable to us as are the AHP'S."

"We do need more male staff. Our bank male staff are excellent."

"Staff come to release you for breaks and when a patient is presenting as more difficult."

"Multi-disciplinary team works well together. Staff are supportive of ideas and I feel very comfortable to share them."

"I am very comfortable here. I wish the art room was bigger."

5.0 The Four Stakeholder Outcomes and What We Found

5.1 Is Care Safe?

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

Key Indicator S1 - There are systems in place to ensure unnecessary risks to the health, welfare or safety of patients are identified, managed and where possible eliminated.

Examples of Evidence:

- ✓ Patients and their representatives were involved in designing and managing their own risk assessments and risk management plans.
- ✓ Risk assessments and management plans were in place and were individualised and included proactive and reactive strategies. These were completed by the multi-disciplinary team.
- ✓ Risks that were identified informed patients care plans.
- ✓ All staff carried personal alarms.

Areas for Improvement:

Risk assessments

- ✘ Risk assessments and management plans were not reviewed in accordance with Promoting Quality Care (PQC) Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services May 2010.
- ✘ Two out of the four risk assessments were not up to date.
- ✘ There was a duplication of risk assessments in patients care documentation.

Key Indicator S2 - The premises and grounds are safe, well maintained and suitable for their state of purpose.

Examples of Evidence

Ward Environment: Inspectors assessed the ward's physical environment using a ward observational tool and check list.

- ✓ The Health and Safety assessment was completed in June 2016; all recommendations made had been met.

- ✓ The fire risk assessment was completed in June 2015; all recommendations made had been met. The Fire Risk Assessment will be reviewed and updated on 10th August 2016.

- ✓ A safety climate survey was completed in June 2016 with results showing a positive outcome.

- ✓ A ligature risk assessment was completed on May 2016; all recommendations made had been met.

- ✓ The ward environment was clean and clutter free.

- ✓ The medical room was clean and well organised. Emergency equipment was available, and records reviewed evidenced that the equipment had been checked every week.

- ✓ Staff were present in the communal areas at all times during the inspection.

- ✓ Patients had their own bedrooms and en-suite facilities.

- ✓ Patients could access a phone in private.

- ✓ The signage around the ward assisted patients with orientation.

- ✓ Patients had access to a safe outside area.

Area for Improvement:

Seclusion room

- ✘ There was no bed in the seclusion room.

- ✘ There were safety hazards in the seclusion room, particularly in the bathroom facility.

- ✘ Walls and floors were not of a seamless construction.

- ✘ Walls were not painted a calm, definitive colour and the room required to be repainted. (A minor works request has been submitted).

✘ The door opened inward with the potential hazard that a patient could use the bathroom door to hold the exit door open.

✘ There was no clock for the patient to view in the seclusion room.

Key Indicator S3 - There are at all times, suitably qualified, competent and experienced persons working in the facility.

Examples of Evidence

✓ The nine members from the multi-disciplinary team interviewed confirmed they knew the procedure for escalating concerns in relation to patient safety.

✓ The multi-disciplinary team stated they did not work beyond their role, experience or training.

✓ The multi-disciplinary team had been agreed and all members of the team were available.

✓ With the exception of five staff who were on the waiting list for manual handling and one staff on the waiting list for physical intervention training (MAPA) all staff working on the ward had received up to date mandatory training.

Area for Improvement:

No areas for improvement identified.

Key Indicator S4 – Patients are detained appropriately with information provided about their rights and how to make a complaint.

Examples of Evidence:

✓ Patients who were detained in accordance with the Mental Health (Northern Ireland) Order 1986 had been informed of their rights. Two patients had recently attended their Mental Health Review Tribunal.

✓ Information in relation to patients' rights was available in an easy to read format and included detention processes and how to make a complaint.

✓ Patients and relatives confirmed they knew how to make a complaint.

- ✓ Patients had their capacity to consent assessed, documented and reviewed every week at the ward round. Where there was evidence that a patient did not have capacity to consent, best interest decision making processes were followed.

- ✓ Inspectors observed staff gaining consent from patients during the inspection.

- ✓ A record of complaints was maintained on the ward. There was one complaint between 1 April 2015 and 31 March 2016. The complaint had been managed appropriately in accordance with trust policy and procedure and had been fully resolved.

Area for Improvement:

No areas for improvement were identified.

5.2 Is Care Effective?

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

Key Indicator E1 - Comprehensive co-produced personal well-being plans/care plans are in place to meet the assessed needs of patients. Care and treatment is evaluated for effectiveness. Effective discharge planning arrangements are in place.

Examples of Evidence:

- ✓ Inspectors reviewed care documentation in relation to four patients. Assessments were noted to be individualised, person centred, comprehensive and evidenced patient and relative involvement.

- ✓ Assessments were available in an easy read format, which facilitated patients to be involved in their assessment.

- ✓ From the assessments reviewed there was evidence that timely referrals were made to speech and language therapy and physiotherapy.

- ✓ Each patient's assessment was reviewed every week and amended accordingly.

- ✓ Care plans were reviewed, evaluated and updated every week if required.

- ✓ The occupational therapist had completed an intervention plan and schedule where appropriate for patients and recorded their intervention in the patients care documentation.

- ✓ The psychologist and the behaviour nurse therapist recorded their intervention in each patient's progress notes.

- ✓ There was one multi-disciplinary file.

- ✓ Each patient had a communication assessment and associated communication plans completed.

- ✓ Patients had sensory integration plans in place where required.

- ✓ Patients had timely access to specialist assessments and interventions according to their assessed needs and there was a range of evidenced based care and treatment options available.

- ✓ Each patient had an assessment completed in relation to their physical needs. Patient's physical health needs were monitored throughout their admission.

- ✓ Patients' needs were reviewed twice weekly at the ward round and therapeutic meeting.

- ✓ The impact of care and treatment was measured for effectiveness. This information was available in a graph format. The reduction in physical intervention, seclusion and the use of PRN medication was clearly recorded.

Area for improvement:

<u>Psychology and behaviour support services</u>

- ✘ There was no psychological care / intervention plan in place.

- ✘ There was no evidence of any functional behaviour assessments in the care documentation reviewed.

- ✘ The four behaviour management plans reviewed were; not patient centred, easily understood, too complex, and focused mainly on risky behaviours with little consideration given to the overall assessed needs of the person.

- ✘ Patients who required support with their communication would not have understood the content of their behaviour management plans. These plans were not easily interpreted by the range of staff that were required to implement them.

- ✘ There was a brief formulation documented in each patient's behaviour management plan. However, this did not link in with the functions of the behaviour and there was limited reference to the formulation in the actual behaviour management plan. It was documented, for example, that a patient had anxiety. However there was no further mention of anxiety in the management plan.

- ✘ None of the staff working on the ward had received any training in proactive ways to support people who present with behaviours that are challenging.

Care documentation

- ✘ Due to the high volume of records maintained for patients who have been receiving learning disability services for many years, there was no concise summary of each patient's psychiatric history, behavioural difficulties, treatments, therapies prescribed and their therapeutic benefits. The patient's family history, developmental history and social functioning could not be readily established.

- ✘ It was also difficult to establish the nature and efficacy of any psychological interventions that had been tried over the years.

- ✘ There were duplicated records which were out of date and non-essential information contained in each patient's care documentation. This made it difficult to review the patient's journey.

- ✘ The records of the ward rounds were inconsistently completed with the agreed actions, the responsible person and a timeframe for achievement.

- ✘ The minutes of the therapeutic meetings provided a description of the patient's week. There was no documented evidence of a review of the therapeutic goal and intervention from the previous week.

Environment

- ✘ There was inadequate space for interviewing patients and relatives, and for therapeutic and psychological interventions.

Key Indicator E2 - Autonomy and Independence is promoted and the use of restrictive practice(s) is minimised

Examples of Evidence:

✓ The design of the ward was enabling and least restrictive.

✓ The use restrictive practices were based on assessed need and were used as a last resort.

✓ The ward manager maintained a monthly record on the number of restrictive interventions used on the ward and analysed these at ward level for learning.

Area for improvement:

No areas for improvement identified.

5.3 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.

Key Indicator C1 - **There is a culture/ethos that supports the values of dignity and respect and patients are responded to compassionately.**

Observations - 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.

Inspectors 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.

Examples of Evidence:

Observations of interactions between staff and patients/visitors were completed throughout the days of the inspection. Ten interactions were recorded in this time period. The outcomes of these interactions were as follows:

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

✓ Five patients confirmed they were treated with dignity and respect.

✓ There were 10 interactions observed and these were assessed as positive. Staff were noted to;

- be considered and compassionate,
- be respectful and treat patients with dignity,
- respond in an appropriate and timely manner to patients who required assistance and support,
- have a good understanding of meeting the needs of patients who required support with their communication,
- respond compassionately to patients who were distressed,
- engage and support patients with a good variety of appropriate activities, and;
- be familiar with each individual patient's needs.

✓ Five relatives all confirmed their family member was treated with dignity and respect.

Area for Improvement:

There were no areas for improvement identified.

Key Indicator C2 - There are systems in place to ensure that the views and opinions of patients, and/or their representatives are sought and taken into account in all matters affecting them.

Examples of Evidence:

- ✓ There was evidence in the four sets of care documentation reviewed that patients and/or their representatives were involved in decisions in relation to care and treatment and were offered the opportunity to attend meetings.
- ✓ Five relatives and five patients also confirmed they were involved in decisions about care and treatment.
- ✓ There was an advocacy service available.
- ✓ There was evidence in the care documentation that care and treatment had been explained to the patient.
- ✓ Information on care and treatment was available in an easy to read format.
- ✓ Five patients confirmed that staff always asked their permission before care delivery.
- ✓ There was evidence that staff had explained the need for the use of restrictive practices in the four sets of care documentation reviewed.
- ✓ There was information displayed on entry to the ward and in the ward information booklet in relation to deprivation of liberty.
- ✓ Staff interviewed confirmed that patients were debriefed following any episodes of restriction i.e. physical intervention, seclusion.
- ✓ Each patient had a risk assessment and management plan which demonstrated that any restrictions were used as; a last resort, were necessary and were proportionate to the risk.
- ✓ All five patients and five relatives spoke highly of staff on Dorsy ward and confirmed they were satisfied with the care and treatment provided.
- ✓ Patients and relatives had the opportunity to comment on their care by completing a patient satisfaction survey and during weekly patient forum meetings.
- ✓ The ward retained a record of compliments.

Area for Improvement:

Advocacy

- ✘ The advocacy service had recently been reviewed. To access the service staff make a referral. Staff stated that this can sometimes cause a delay in accessing the service. Patients could be discharged before having the opportunity to avail of this service.

5.4 Is The Service Well Led?

Effective leadership, management and governance which create a culture focused on the needs and experiences of patients in order to deliver safe, effective and compassionate care.

Key Indicator WL1 - There are appropriate management and governance systems in place to meet the needs of patients.

Examples of Evidence:

- ✓ Nine members of the multi-disciplinary team and two visiting professionals were interviewed. All staff confirmed that they aware of their roles and responsibilities.

- ✓ All staff confirmed the action they would take in relation to any concerns. All staff knew the trust policy and procedure in relation to safeguarding vulnerable adults and child protection concerns.

- ✓ All staff were aware of the trust whistle blowing policy and procedure.

- ✓ There was evidence that medication audits were completed every four months.

- ✓ Medication prescription sheets were audited four times daily after every medication round.

- ✓ A pharmacist attended the ward every Monday and reviewed medication.

- ✓ Sessional medical officer reviewed the medication records for all patients on the ward and noted that there were no issues.

- ✓ There was a system in place to audit patients care documentation. These were completed by the band 6 and band 7 nurse. This audit tool is currently under review.

- ✓ All staff interviewed confirmed they knew the policy and procedure for reporting incidents and accidents.

- ✓ Records showed that incidents were being reported. Staff were able to describe what should be reported, to whom and the trust procedure. Incidents were reported to the nurse in charge and recorded electronically on the DATIX system.

- ✓ There was a governance system in place to review and analyse incidents. The trust clinical and social care governance co-ordinator reviewed the incidents on the datix system. The incidents were broken down into categories. This information is collated and available on a dash board; this can be accessed by the ward manager and was available to inspectors.

- ✓ There was evidence in the minutes of the three monthly governance meetings that incidents were discussed with the ward manager. There was evidence that this information was shared with staff at ward level through staff meetings.

- ✓ The ward manager maintained a monthly record of the number of times restrictive interventions have been used. This record was available and reviewed by inspectors.

- ✓ Staff meetings were convened every month. There were standard items on the agenda including relevant issues discussed at governance level.

- ✓ There was evidence that the minutes of the meetings were shared with staff who could not attend the meetings.

- ✓ All staff interviewed stated there was good working relationships between the multi-disciplinary team and did not raise any issues.

- ✓ Inspectors observed the good working relationships and the support within the team, most members of the multi-disciplinary team including those that were not working on the ward made themselves available during the inspection with the exception of the consultant clinical psychologist.

Areas for Improvement:

Governance overview of incidents

- ✘ There were 676 incidents recorded between 1 April 2015– 31 March 2016. The majority of these incidents were in relation to physical abuse, assault and violence to staff and patients. Although the data was available and discussed through the governance mechanism there was no evidence of any proactive strategies to address the number of incidents.

- ✘ The frequency of the use of restrictive practices was reviewed at ward level. However this information was not forwarded to the governance team for oversight and review.

Staff meetings

- ✘ There was no evidence in the staff meetings that evidence based practice, new relevant standards, or new best practice was discussed. This would enhance the dissemination of learning and should be referenced on the agenda of these meetings and this service.

Policies and procedures

- ✘ Some policies and procedures were out of date; however this has been identified during another inspection in the Bluestone unit as an issue for the SHSCT and will be not be included in the Dorsy Quality Improvement Plan.

Key Indicator WL2 - There are appropriate management and governance systems in place that drive quality improvement.

Examples of Evidence:

- ✓ The ward had a patient's satisfaction survey. This can also be completed by relatives. The survey is completed during admission and on discharge.

- ✓ The satisfaction survey was available in a format that met the communication needs of most of the patient's, i.e. an easy to read format.

- ✓ Inspectors reviewed four satisfaction surveys completed in July 2016. Two surveys were completed by patients including one who had recently been discharge and two were completed by relatives. All responses were noted to be positive.

- ✓ A record of complaints and compliments was maintained. There was one formal complaint recorded in relation to care practice, the complaint had been investigated in accordance with trust policy and procedure and was fully resolved.

- ✓ Patient forum meetings were convened every week. Minutes were recorded and action plans were developed.

Areas for Improvement:

Service Improvement

- ✘ There were no service improvement initiatives displayed e.g. number of compliments, complaints, patient experience surveys etc.

Key Indicator WL3 - There is a clear organisational structure and all staff are aware of their roles, responsibility and accountability within the overall structure. There are appropriate supervision arrangements in place.

Examples of Evidence:

- ✓ All staff interviewed confirmed they knew the organisational and management structure.

- ✓ All staff explained their lines of responsibility and understood their specific roles and responsibilities.

- ✓ The records reviewed pre inspection evidenced that all staff working on the ward and the multi-disciplinary team had received up to date supervision and appraisal.

Area for Improvement:

No areas for improvement identified.

Key Indicator WL4 - There are effective staffing arrangements in place to meet the needs of the patients.

Examples of Evidence:

- ✓ On review of the pre-inspection information there was no evidence that agency staff were used on the ward.

- ✓ Staff rotas for the previous three months showed that all shifts had been fully staffed. Bank staff that were used had previous experience of working on the ward. There was evidence that all bank staff got a comprehensive induction to the ward.

- ✓ There were the following vacancies on the ward; 3.42 WTE Band 5 staff and 2.52 WTE Band 3 staff. However the ward has recently recruited two Band 5 staff and an additional waiting list for staff is in place to address shortages.

- ✓ The multi-disciplinary team for the facility is agreed and all staff were available.

- ✓ Patients confirmed that they had regular 1:1 time with their named nurse.

- ✓ All staff interviewed confirmed that they had access to their line manager, and there was a rota in place for out of hours contact.

- ✓ All staff interviewed confirmed that they were given the opportunity to make suggestions or raise concerns and felt listened to.

Areas for Improvement:

No areas for improvement identified.

6.0 Good Practice Noted

Inspectors evidenced that the ward staff team continued to improve practices on the ward.

Patient have access to a MDT, who work in the unit. The ward's MDT worked effectively together and staff informed inspectors that they enjoyed working on the ward.

There was a good range of appropriate activities available for patients.

7.0 Quality Improvement Plan

Areas for improvement are summarised below. The trust, in conjunction with ward staff, should provide a compliance plan to RQIA detailing the actions to be taken to address the areas identified.

Key areas for improvement were discussed with the ward manager and other staff from the trust involved in providing care/treatment to patients in this ward as part of the inspection process.

The timescale for action on the areas for improvement commenced from the day of the inspection. The quality improvement plan requires to be completed by the trust detailing the actions the trust intend to take to make the required improvement and returning to RQIA within 28 days of receipt.

On return to RQIA the quality improvement plan will be assessed by the inspector.

Areas for Improvement		Timescale for Implementation in Full
Priority 1		
1	There were no priority 1 areas for improvement.	
Priority 2		
2	Risk assessments Risk assessments and management plans were not reviewed in accordance with Promoting Quality Care (PQC) Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services May 2010. Two out of the four risk assessments were not up to date. There was a duplication of risk assessments in patients care documentation.	28 October 2016
3	Environment There was inadequate space for interviewing patients and relatives, and for therapeutic and psychological interventions.	28 October 2016
4	Advocacy The advocacy service had recently been reviewed. To access the service staff make a referral. Staff stated that this can sometimes cause a delay in accessing the service. Patients could be discharged before having the opportunity to avail of this service.	28 October 2016
5	Staff meetings There was no evidence that evidence based practice, new relevant standards, or new best practice was discussed at staff meetings. This would enhance the dissemination of learning and should be referenced on the agenda of these meetings and this service.	28 October 2016
6	Service improvement There were no service improvement initiatives displayed e.g. number of compliments, complaints, patient experience surveys, outcomes etc.	28 October 2016

Priority 3		
7	<u>Seclusion room</u> There was no bed in the seclusion room. There were safety hazards in the seclusion room, particularly in the bathroom facility. Walls and floors were not of a seamless construction. Walls were not painted a calm, definitive colour and the room required to be repainted. (A minor works request has been submitted). The door opened inward with the potential hazard that a patient could use the bathroom door to hold the exit door open. There was no clock for the patient to view in the seclusion room.	28 January 2016
8	<u>Psychology and behaviour support services</u> There was no psychological care / intervention plan in place. There was no evidence of any functional behaviour assessments in the care documentation reviewed. The four behaviour management plans reviewed were; not patient centred, easily understood, too complex, and focused mainly on risky behaviours with little consideration given to the overall assessed needs of the person. Patients who required support with their communication would not have understood the content of their plans. These plans were not easily interpreted by the range of staff that were required to implement them. There was a brief formulation documented in each patient's behaviour management plan. However, this did not link in with the functions of the behaviour and there was limited reference to the formulation in the actual behaviour management plan. It was documented, for example, that a patient had anxiety. However there was no further mention of anxiety in the management plan.	28 January 2016

	None of the staff working on the ward had received any training in proactive ways to support people who present with behaviours that are challenging.	
9	<u>Care documentation</u> Due to the high volume of records maintained for patients who have been receiving learning disability services for many years, there was no concise summary of each patient's psychiatric history, behavioural difficulties, treatments, therapies prescribed and their therapeutic benefits. The patient's family history, developmental history and social functioning could not be readily established. It was also difficult to establish the nature and efficacy of any psychological interventions that had been tried over the years. There were duplicated records which were out of date and non-essential information contained in each patient's care documentation. This made it difficult to review the patient's journey. The records of the ward rounds were inconsistently completed with the agreed actions, the responsible person and a timeframe for achievement. The minutes of the therapeutic meetings provided a description of the patient's week. There was no documented evidence of a review of the therapeutic goal and intervention from the previous week.	28 January 2016
10	<u>Governance overview of incidents</u> There were 676 incidents recorded between 1 April 2015 – 31 March 2016. The majority of these incidents were in relation to physical abuse, assault and violence to staff and patients. Although the data was available and discussed through the governance mechanism there was no evidence of any proactive strategies to address the number of incidents. The frequency of the use of restrictive practices was reviewed at ward level. However this information was not forwarded to the governance team for oversight and review.	28 January 2016

Definitions for Priority Improvements

PRIORTY	TIMESCALE FOR IMPLEMENTATION IN FULL
1	This can be anywhere from **24 hours to 4 weeks from the date of the inspection** – the specific date for implementation in full will be specified
2	Up to **3 months** from the date of the inspection
3	Up to **6 months** from the date of the inspection

HSC Trust Quality Improvement Plan

WARD NAME	Dorsy	**WARD MANAGER**	Geraldine Dinsmore	**DATE OF INSPECTION**	26 – 28 July 2016
NAME(S) OF PERSON(S) COMPLETING THE IMPROVEMENT PLAN	Geraldine Dinsmore	**NAME(S) OF PERSON(S) AUTHORISING THE IMPROVEMENT PLAN**	Bryce McMurray		

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

The areas where improvement is required, as identified during this inspection visit, are detailed in the inspection report and quality improvement plan.

The improvement plan should be completed and returned to team.mentalhealth@rqia.org.uk from the HSC Trust approved e-mail address, by 6 October 2016.

Please password protect or redact information where required.

PRIORTY	TIMESCALE FOR IMPLEMENTATION IN FULL
1	This can be anywhere from **24 hours to 4 weeks from the date of the inspection** – the specific date for implementation in full will be specified
2	Up to **3 months** from the date of the inspection
3	Up to **6 months** from the date of the inspection

Part A

Priority 1: Please provide details of the actions taken by the Ward/Trust in the timeframe **immediately** after the inspection to address the areas identified as **Priority 1**.

	Area identified for Improvement	Timescale for full implementation	Actions taken by Ward/Trust	Attached Supporting Evidence	Date completed
1	***Key Outcome Area – Is Care Safe?*** There are no priority one areas identified for improvement				
2	***Key Outcome Area – Is Care Effective?*** There are no priority one areas identified for improvement				
3	***Key Outcome Area – Is Care Compassionate?*** There are no priority one areas identified for improvement				
4	***Key Outcome Area – Is Care Well Led?*** There are no priority one areas identified for improvement				

Part B

Priority 2: Please provide details of the actions proposed by the Ward/Trust to address the areas identified for improvement. The timescale within which the improvement must be made has been set by RQIA.

	Area identified for improvement	Timescale for improvement	Actions to be taken by Ward	Responsibility for implementation
1	***Key Outcome Area – Is Care Safe?*** <u>Risk assessments</u> Risk assessments and management plans were not reviewed in accordance with Promoting Quality Care (PQC) Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services May 2010. Two out of the four risk assessments were not up to date. There was a duplication of risk assessments in patients care documentation. **Quality Standard 5.3.1 (a)** This area has been identified for improvement for the **first** time.	28 October 2016	Ward Sister will meet with the Team Leads for each locality to highlight the need for updated and signed PQC Risk documentation. Appendix 4 of the PQC will be completed on admission. Risk Reviews completed during admission will be recorded on this document and will be sent to the Keyworker on discharge. This is reviewed at the weekly MDT meeting by the Ward Sister/Charge Nurse. It is anticipated that the Learning Disability Services will be transferred to electronic care records (PARIS) in the new year which will in part manage this issue.	Ward Sister and Community Team Leads
2	***Key Outcome Area – Is Care Effective?*** <u>Environment</u>	28 October 2016	A system of indentified space within resources of Dorsy and the Ferns Resource Centre is in place, any issues to be escalated via Ward Sister or the	Ward Sister and Consultants

	There was inadequate space for interviewing patients and relatives, and for therapeutic and psychological interventions. **Quality Standard 6.3.2 (a)** This area has been identified for improvement for the **first** time**.**		Patient Flow/Bed Management Coordinator.	
3	***Key Outcome Area – Is Care Compassionate?*** <u>Advocacy</u> The advocacy service had recently been reviewed. To access the service staff make a referral. Staff stated that this can sometimes cause a delay in accessing the service. Patients could be discharged before having the opportunity to avail of this service. **Quality Standard 6.3.2 (a)** This area has been identified for improvement for the **first** time.	28 October 2016	In order to ensure there is safe and timely access to Advocacy Services there is a contract between Southern Trust and Disability Action. As part of the contract agreement, Disability Action must receive a referral and have it screened before it is allocated to an independent advocate. The person screening will determine if the referral is urgent or routine and will allocate accordingly. A patient can access an independent advocate via self-referral or a referral from a member of the ward multidisciplinary team, or community practitioners such as the individual's case manager, nurse, GP. Details of how to access an independent advocate is displayed in Dorsy. Disability Action adopts an open referral system and copy of the referral form is available in Dorsy. The allocated independent advocate will garner further information post allocation. Disability Action provides an issue based advocacy service. Completion of the 'reason for referral' aids	Ward Sister and Advocate

			in targeting advocacy to those most in need for the advice and support they most require of the Independent Advocate. The Independent Advocate will attend all weekly ward rounds for those to whom they are an advocate and for those whom they have not received a referral. They will be generally present on the Ward at least one more day per week. To safeguard Service User's rights, a referral is required prior to advocacy involvement, with the exception of attending Ward rounds. The Ward Sister will meet with the Advocate on 4th October to ensure that the pathway for patients to access an advocate is clear. This will then be communicated to the Multidisciplinary team through Staff meetings. All disciplines will be encouraged to continue to use the independent advocacy service when it is required and a referral form will be completed to gain entry to the service. The quality of referrals will be monitored by Disability Action and reported on to the Ward Sister should there be any deficit in information provided. This will then be addressed case by case and reported to the Bluestone Coordinator quarterly.	

			The ward sister through attendance lists will monitor the presence of the Advocate in the Ward Rounds and in the Ward with patients and provide a report quarterly to the Bluestone Coordinator.	
4	***Key Outcome Area – Is Care Well Led?*** <u>Staff meetings</u> There was no evidence that evidence based practice, new relevant standards, or new best practice was discussed at the staff meetings. This would enhance the dissemination of learning and should be referenced on the agenda of these meetings and this service. **Quality Standard 5.3.3 (f)** This area has been identified for improvement for the **first** time.	28 October 2016	A Multi-disciplinary evidence based practice group has been established and a programme of topics to be shared has been drawn up. This group will meet monthly.	Ward Sister, Consultants, Occupational Therapy, Behaviour Nurse and Psychology
5	<u>Service Improvement</u> There were no service improvement initiatives displayed e.g number of compliments, complaints, patient experience surveys, outcomes etc. **Quality Standard 8.3 (k)** This area has been identified for improvement for the **first** time.	28 October 2016	The initiatives that are in place will be displayed on the ward and in staff areas. This will be added to as service improvements take place and updated on a monthly basis.	Ward Sister

Part C

Priority 3: Please provide details of the actions proposed by the Ward/Trust to address the areas identified for improvement. The timescale within which the improvement must be made has been set by RQIA.

	Area identified for improvement	Timescale for improvement	Actions to be taken by Ward	Responsibility for implementation
1	***Key Outcome Area – Is Care Safe?*** <u>Extra care suite (this area is used for seclusion)</u> The following was observed in this area: There was no bed. There were safety hazards particularly in the bathroom facility. Walls and floors are not of a seamless construction. Walls were not painted a calm, definitive colour and the room required to be repainted. (A minor works request has been submitted). The door opened inward with the potential hazard that a patient could use the bathroom door hold the exit door open. There was no clock for the patient to view. **Quality Standard 5.3.3 (f)** This area has been identified for improvement for the **first** time.	28 January 2017	Ward Sister met with MAPA Trainers on 27th September to discuss the Extra Care Suite. They advised that it would be unsafe for both patients and staff to put a bed in the Extra Care Suite. There will be a Health & Safety review with Health & Safety Officer for this area. The area has been repainted. Given the potential risks identified the En Suite door has been removed and alternatives are being considered with Estates services. Staff will be aware of preserving dignity. A clock will be placed in the outer area of the Extra Care Suite.	Head of Service, Ward Sister and Estates

2	***Key Outcome Area – Is Care Effective?*** <u>Psychology and Behaviour Support services</u> There was no psychological care / intervention plan in place. There was no evidence of any functional behaviour assessments in the care documentation reviewed. The four behaviour management plans reviewed were; not patient centred, easily understood, too complex, and focused mainly on risky behaviours with little consideration given to the overall assessed needs of the person. Patients who required support with their communication would not have understood the content of their plans. These plans were not easily interpreted by the range of staff who were required to implement them. There was a brief formulation documented in each patients' behaviour management plan. However, this did not link in with the functions of the behaviour and there was limited reference to the formulation in the actual behaviour management plan. It was documented, for example that a patient had anxiety. However there was no further mention of anxiety in the management plan. None of the staff working on the ward had received any training in proactive ways to support people who present with behaviours that are challenging. **Quality Standard 5.3.1 (a)** This area has been identified for improvement for the **first** time.	28 January 2017	There is now a suite of Functional Behaviour Assessment Tools available in the Dorsy Unit. A copy of the completed Assessments will be available. The Behaviour Nurse Therapist is currently reviewing Behaviour Support Plans.This will include consideration of easy read format. The Ward Manager will explore interventions such as Positive Behaviour Support training to determine if they can offer additional value.	Psychology and Behaviour Nurse Therapist

3	Care documentation Due to the high volume of records maintained for patients who have been receiving learning disability services for many years, there was no concise summary of each patient's psychiatric history, behavioural difficulties, treatments, therapies prescribed and their therapeutic benefits. The patient's family history, developmental history and social functioning could not be readily established. It was also difficult to establish the nature and efficacy of any psychological interventions tried over the years. There were duplicated records which were out of date and non-essential information contained in each patient's care documentation. This made it difficult to review the patient's journey. The records of the ward rounds were inconsistently completed with the agreed actions, the responsible person and a timeframe for achievement. The minutes of the therapeutic meetings provided a description of the patient's week. There was no documented evidence of a review of the therapeutic goal and intervention from the previous week. **Quality Standard 5.3.1 (a)** This area has been identified for improvement for the **first** time.	28 January 2016	A concise mental health summary will be formulated and entered clearly into each patient's notes including a summary of treatments and therapies previously used. This will be actioned by the Ward Doctor with supervision from their Consultant. The Named Nurse and Ward Clerk will ensure that the file will only contain current relevant information. The record of the MDT meetings will be discussed at the Operational Meeting to ensure that Ward Round Proforma is completed fully. The Ward Round Proforma will be reviewed by the Multi-disciplary Team. The minutes of the Therapeutic Meetings will now evidence that there has been a review of the therapeutic interventions towards the identified goal.	Multi-disciplinary Team
3	***Key Outcome Area – Is Care Compassionate?***			

	There were no priority 3 areas for improvement identified.			
4	***Key Outcome Area – Is Care Well Led?*** <u>Governance overview of incidents</u> There were 676 incidents recorded between 1 April 2015– 31 March 2016. The majority of these incidents were in relation to physical abuse, assault and violence to staff and patients. Although the data was available and discussed through the governance mechanism there was no evidence of any proactive strategies to address reducing the number of incidents. The frequency of the use of restrictive practices was reviewed at ward level. However this information was not forwarded to the governance team for oversight and review. **Quality Standard 5.3.2 (c)** This area has been identified for improvement for the **first** time.	28 January 2017	In order to be proactive the ward implements a variety of interventions both therapeutic and social in order to ensure the environment is as calm and therapeutic as possible. This will be reflected in the Risk Management Control Measures. The Ward Team will explore interventions such as Positive Behaviour Support training to determine if they can offer additional value. This will be added to the Governance Agenda.	Dorsy Governance Team

TO BE COMPLETED BY RQIA

Inspector comment (delete as appropriate)	**Inspector Name**	**Date**
I have reviewed the Trust Improvement Plan and I am satisfied with the proposed actions	Wendy McGregor	10 October 2016