Unannounced Follow Up Inspection Report
14 and 15 March 2017

Dorsy Ward
Assessment and Treatment
Bluestone Unit, 68, Lurgan Road, Portadown
BT63 5QQ

Tel No: 02828 360665

Inspectors: Wendy McGregor and Professor Nichola Rooney

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service provider from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

Dorsy ward is a ten bedded mixed gender assessment and treatment inpatient unit for patients with a learning disability. On the days of the inspection there were nine patients on the ward; five patients were detained 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. An independent advocacy service was also available for patients by referral.

3.0 Service details

Responsible person: Stephen McNally	**Ward Manager: Geraldine Dinsmore**
Category of care: Assessment and Treatment	**Number of beds: 10**
Person in charge at the time of inspection: **Day 1 – Theresa O'Neill** **Day 2 – Geraldine Dinsmore**	

4.0 Inspection summary

An unannounced follow-up inspection took place over two days on 14 - 15 March 2017.

The inspection sought to assess progress with issues raised from the most recent previous unannounced inspection dated 26 – 28 July 2016.

A RQIA sessional consultant psychologist was part of the inspection team.

The findings of this report will provide the Trust with the necessary information to assist them to fulfil their responsibilities, enhance practice and service user experience.

4.1 Inspection outcome

Total number of areas for improvement	11

The 11 total number of areas for improvement comprise:

- Five restated for a second time
- Five new areas for improvement
- One not assessed

These are detailed in the Provider Compliance Plan (PCP) on pages 17 – 21.

Areas for improvement and details of the PCP were discussed with senior trust representatives, members of the multi-disciplinary team, the ward manager and ward staff as part of the inspection process. The timescales for completion commenced from the date of inspection.

Escalation action resulted from the findings of this inspection. A letter of serious concerns was sent to the Director for Mental Health and Learning Disability on 22 March 2017 requesting an action plan to the serious concerns by 3 April 2017. The Director for Mental Health and Learning Disability responded on the 3 April 2017 with a clear, robust action plan which detailed the accountability and responsibility for the actions to be addressed.

The escalation policies and procedures are available on the RQIA website.
https://www.rqia.org.uk/who-we-are/corporate-documents-(1)/rqia-policies-and-procedures/

5.0 How we inspect

The inspection was underpinned by:

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

The following areas were examined during the inspection:

- Psychology and behaviour support service.
- Care Documentation in relation to four patients.
- Ward environment.
- Advocacy service.
- Activity schedule.
- Timetable for sharing best practice.

6.0 The inspection

6.1 Review of areas for improvement from the last unannounced inspection dated 26 – 28 July 2016

The most recent inspection of Dorsy Ward was an unannounced inspection. The completed PCP was returned and approved by the responsible inspector. This PCP was validated by inspectors during this inspection.

<table>
<tr><th colspan="2">Areas for Improvement</th><th>Validation of Compliance</th></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Standard 5.3.1 (a)

Stated: First Time</td><td><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.</td><td rowspan="2">Partially Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:

Inspectors reviewed risk assessments and management plans in relation to four patients.

Some progress was made as the risk assessments were noted to be up to date and there were no duplications in the four sets of care documentation reviewed.

None of the risk assessments had been 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.

Reviews detailed a description of incidents that occurred but did not address the assessed risks in the comprehensive risk assessment.

As this area for improvement was assessed as partially met, the areas that were not met will be restated a second time.</td></tr>
</table>

Area for improvement 2 **Ref**: Standard 6.3.2 (a) **Stated:** First Time	<u>Environment</u> There was inadequate space for interviewing patients and relatives, and for therapeutic and psychological interventions.	**Met**
	Action taken as confirmed during the inspection: Inspectors noted that additional rooms were now available for interviewing patients and relatives. Inspectors were informed that these rooms could now be used for therapeutic and recreational activities.	
Area for improvement 3 **Ref**: Standard 6.3.2 (a) **Stated:** First Time	<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.	**Met**
	Action taken as confirmed during the inspection: There was evidence that the advocate attends the ward every week and meets with patients. Ward staff stated there were no issues with referring patients to the independent advocate and patients could access the service without delay. It was noted that when required the independent advocate attends the weekly multi-disciplinary ward rounds.	

<table>
<tr>
<td rowspan="2">Area for improvement 4

Ref: Standard 5.3.3 (f)

Stated: First Time</td>
<td><u>Staff meetings</u>

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.</td>
<td rowspan="2">Met</td>
</tr>
<tr>
<td>Action taken as confirmed during the inspection:

A plan for sharing evidence and relevant areas in relation to care and practice was developed.

This involved members of the multi-disciplinary team delivering a presentation every month to all staff. Inspectors reviewed the schedule and noted the following:

<table>
<tr><td>• November 2016</td><td>Rapid tranquilisation</td><td>consultant psychiatrist</td></tr>
<tr><td>• December 2016</td><td>Restrictive practice</td><td>deputy ward manager</td></tr>
<tr><td>• January 2017</td><td>Promoting Quality Care</td><td>behaviour nurse therapist</td></tr>
<tr><td>• February 2017</td><td>Cognitive therapies</td><td>consultant clinical psychologist</td></tr>
<tr><td>• March 2017</td><td>Sensory integration</td><td>occupational therapist</td></tr>
<tr><td>• April 2017</td><td>no topic agreed</td><td>consultant psychiatrist</td></tr>
<tr><td>• May 2017</td><td>no topic agreed</td><td>consultant psychiatrist</td></tr>
</table>

The schedule and the presentations were available for staff working on the ward.</td>
</tr>
</table>

Area for improvement 5 **Ref**: Standard **8.3 (k)** **Stated:** First Time	<u>Service Improvement</u> There were no service improvement initiatives displayed; e.g. number of compliments, complaints, patient experience surveys, outcomes.	**Carried forward to the next inspection**
	Action taken as confirmed during the inspection: This area for improvement was not assessed during this inspection.	
Area for improvement 6 **Ref**: Standard **5.3.3 (f)** **Stated:** First Time	<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 to hold the exit door open. There was no clock for the patient to view.	**Not Met**
	Action taken as confirmed during the inspection: Inspectors observed the Extra Care Suite. This area is primarily used for seclusion. There was no bed, although inspectors were informed that one had been ordered. There were serious safety hazards in the bathroom. The toilet seat had been removed by a patient and there were two metal exposed prongs.	

	The camera in the extra care suite was broken, though none of the staff were aware of this. These required urgent attention on the first day of the inspection and were addressed at the request of the inspector. The walls and floors were still not of seamless construction. The room had been painted. The door still opened inwards, however the bathroom door had been removed. A clock was provided, but was not situated were the patient could see it. There was one area of improvement addressed since the last inspection as the room had been painted. This area will be restated a second time.	
Area for improvement 7 **Ref**: Standard 5.3.1 **(a)** **Stated:** First Time	<u>Psychology and behaviour support services</u> There were no psychological care / intervention plans 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 or 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 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	**Not Met**

	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.	
	Action taken as confirmed during the inspection: Inspectors interviewed the associate psychologist and the consultant clinical psychologist. The behaviour nurse therapist was not available for interview due to an extended period of absence. Inspectors also reviewed four sets of care documentation in relation to psychology and behaviour support. There was no psychological / intervention plan in place in the four sets of care documentation reviewed. There was no evidence that the behaviour support service had improved. None of the patients reviewed had a functional behaviour assessment available in their care documentation. There was no evidence that the functions of the behaviour were considered or recorded by staff. The behaviour support plans remain complex and on one occasion used inappropriate language (e.g. boastful talking). The plans continue to focus on risky behaviours and did not consider the overall needs of the patients in a person centred way. Behaviour support plans were not easily understood by patients who require support with their communication or interpreted by the range of staff that were required to implement them. Inspectors noted that one patient had a traffic light behaviour management plan in place; however this was noted to be mostly copied and pasted from one behaviour management plan to the other with the patients name replaced with the word “I”. There was no improvement in patient formulations. Formulations were briefly documented in each patient’s behaviour management plan. However, it	

	still did not link to the functions of the behaviour and there was limited reference to the formulation in the actual behaviour management plan. None of the ward staff had received training in a proactive way to support patients who present with behaviours that are challenging. There was no improvement noted in this area of improvement. This will be stated a second time.	
Area for improvement 8 **Ref**: Standard **5.3.1 (a)** **Stated:** First Time	<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.	**Partially Met**
	Action taken as confirmed during the inspection: Inspectors reviewed care documentation in relation to four patients.	

	There remains a high volume of records for patients who have been receiving learning disability services for many years however there was still 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. Information that was out of date and non-essential remains in the files. Files reviewed had a high volume of community based information including community assessments and community care plans. This information was stored at the beginning of the file. Although this information was used to inform the inpatient assessment it was not relevant to the patient's current presenting needs on the ward. A community care plan was noted to be irrelevant and different to an in-patient care plan. Ward staff stated they were concerned about removing this information from the files. However, inspectors noted this impacted on the large amount of non-essential information in the file and noted that current information was located half way into the file. Information was difficult to locate and it was challenging to review a patient's journey. Inspectors were informed that there are plans to move care records to the patient electronic recording system (PARIS) however there is no date confirmed for this move. Inspectors noted some improvements as there were no duplications evident in the four files reviewed. The records of the weekly ward round records were not consistently completed as there was no record of decisions taken at the ward round. Inspectors reviewed the minutes of the therapeutic meetings available in the patient's files. Inspectors were informed that these meetings were held every week. However in the four files reviewed there was one record of a therapeutic meeting. Inspectors noted that the goals were not person centred and measurable. Outcomes were not evidenced and the responsible person for delivering the actions was not consistently recorded. It was noted in the	

	minutes recorded on 27 January 2017 that the behaviour support plan was required to be reviewed by the psychologist, but there was no evidence that this had been reviewed. There was one area of improvement addressed since the last inspection as there were no duplications in the four sets of care records reviewed. This area will be restated a second time.	
Area for improvement 9 **Ref**: Standard **5.3.2 (c)** **Stated:** First Time	<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.	**Not Met**
	Action taken as confirmed during the inspection: It was unclear what proactive strategies were in place to address the reduction in the number of incidents. Inspectors reviewed the incidents recorded since the last inspection in July 2016. There were 553 recorded incidents on the DATIX system. All of the incidents were appropriately reported. It was noted however that senior management now complete a health and safety leadership walk about, which reviews the number of incidents. There was no evidence presented of any review of the antecedents of these incidents and no evidence of any proactive incidents reduction strategies.	

	There was no evidence that the use of restrictive practices was reviewed by the governance team. This area for improvement will be restated a second time.	

4.3 Additional Inspection findings

Areas of good practice

Patients continue to have access to a good level of appropriate activities on the ward, delivered by the multi-disciplinary team.

It was noted by inspectors that the occupational therapist had attended Wellness and Recovery Action Plan (WRAP) training and used the knowledge of this to develop an easy read, person centred, communication tool for a patient. This tool aimed to support the patient to express their emotions and inform staff on how to best help them when they were distressed. RQIA note this as an area of good practice and would encourage this to be considered for other patients.

A sharing the learning and evidence based practice meetings were held every month and delivered by staff from the multi-disciplinary team. This was open for all grades and disciplines to attend.

4.3 Additional Areas for Improvement

These are stated for the first time and were incorporated into the Provider Compliance Plan (PCP) for this follow up inspection of 14 – 15 March 2017, found on page 17-21. These will be reviewed through future RQIA Inspection Processes.

Extra Care suite (this area is used for seclusion)
PCP Area for Improvement No. 7

Inspectors noted that there was an area in the court yard that could not be viewed by the CCTV camera. Staff were not aware of this, so this was not reported to the estates department for repair.

This area is known by the ward as an extra care suite. However this area does not meet the standard in relation to meeting all the daily living needs of a patient as it does not include a sitting room with safe furnishings. Inspectors remain unclear how a room with the only furnishing provided is a mattress on the floor could be considered as an extra care suite.

Psychology service
PCP Area for Improvement No. 8

The associate psychologists stated they were asked to work beyond their role and remit and could not provide interventions to meet the assessed needs of the patients as they were not trained to do so. Care and treatment was therefore not provided in accordance with NICE Guidelines (Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges May 2015).

Patients did not have access to any evidenced based psychological therapies for example psychosis, trauma, anger management, attachment, obsessive compulsive disorder, autism or forensics.
Patients with forensic requirements did not access care despite the consultant clinical psychologist being dual qualified as a forensic psychologist.

There were two part time associate psychologists working on the ward. The associate psychologists were based in the community.
The consultant clinical psychologist indicated that they do not see any patients but attended the therapeutic meetings one half day per week.

Model of care
PCP Area for Improvement No. 9

Inspectors could not determine what model of care was used to underpin this service. Inspectors recommend that training needs analysis and work force review is completed following the trusts decision on the model of care.

Recording and storage of patient records
PCP Area for Improvement No. 10

Inspectors were informed that behaviour support records were locked in the behaviour support service drawer. Inspectors were concerned that no one could access these records in the absence of the behaviour support nurse.
Inspectors reviewed the psychology records retained in the locked psychology cabinet these were old community files. Inspectors noted that these records did not meet legal or professional standards. Records were not always dated, the wrong date was recorded on one occasion (i.e. the patient's date of birth rather than the date of the assessment) and there were gaps in the progress notes. The consultant clinical psychologist confirmed that there was no governance oversight of the records.

Environment
PCP Area for Improvement No. 11

Inspectors noted on review of the incidents that the exit door beside the extra care suite was broken and reported to the trust estates department on 13 February 2017. The door remained unsecure. It was noted that a patient on enhanced observations had absconded through the same door. There was no evidence that the delay in carrying out this remedial work was recorded on the ward risk register.

Total number of areas for improvement	11

7.0 Provider Compliance Plan

Areas for improvement identified during this inspection are detailed in the provider compliance plan (PCP). Details of the PCP were discussed with senior trust representatives, members of the multi-disciplinary team, ward manager, and ward staff as part of the inspection process. The timescales commence from the date of inspection.

It is the responsibility of the responsible individuals to ensure that all areas for improvement identified within the PCP are addressed within the specified timescales.

The provider compliance plan should be completed and detail the actions taken to meet the areas for improvement identified. The responsible person should confirm that these actions have been completed and return the completed provider compliance plan to Team.MentalHealth@rqia.org.uk for assessment by the inspector.

7.1 Actions to be taken by the service

The provider compliance plan should be completed and detail the actions taken to meet the areas for improvement identified. The responsible person should confirm that these actions have been completed and return the completed provider compliance plan by **8 May 2017.**

Provider Compliance Plan

The responsible person must ensure the following findings are addressed:

Area for Improvement No. 1 **Ref:** Quality Standard 5.3.1 (a) **Stated:** Second time **To be completed by:** 15 June 2017	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.
	Response by responsible individual detailing the actions taken: There are dedicated meetings timetabled for PQC review for all inpatients who require this review. Reviews will be completed by 8 May 2017. This is in accordance with PQC Guidance.
Area for Improvement No. 2 **Ref:** Quality Standard 8.3 (a) **Stated:** First time **To be completed by**: 15 June 2017	Service Improvement There were no service improvement initiatives displayed; e.g. number of compliments, complaints, patient experience surveys and outcomes.
	Response by responsible individual detailing the actions taken: Monthly compliments, complaints and Patient Experience Surveys are displayed throughout the ward. Nursing Quality Indicators (NQIs) are also displayed.
Area for Improvement No. 3 **Ref:** Quality Standard 5.3.1 (e) **Stated:** Second time **To be completed by:** 15 July 2017	Extra care suite (this area is used for seclusion) 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. • The door opened inward with the potential hazard that a patient could use the bathroom door hold the exit door open. • The patients could not view the clock while in seclusion.
	Response by responsible individual detailing the actions taken: The Trust has taken the advice of the MAPA Team which advises that

	for the safety of the patient and staff members that may be in the Extra Care Suite there should not be a bed in the room. A bespoke mattress has been purchased and is in place. If safe to do so the mattress is made up with sheets, pillow and blanket for the patient to sleep on. The Trust have arranged a visit to Muckamore to see if there are additional furnishings that might make the environment more comfortable while preserving patient and staff safety. The identified safety hazards have been removed and the Ward Manager and other members of Multi-Disciplinary Team will visit other units to ensure best practice in relation to care in this area. Extra Care Suite Environment. The following actions have been taken: 1. The toilet brackets have been removed. 2. The cameras are now operational. An additional camera has been installed in the shower room to enhance safe observation. A protocol for its use has been put in place for the protection of patient dignity. 3. The flooring in the unit is to be replaced within the next three weeks subject to the availability of the room. 4. The door into the suite is to be replaced subject to funding. 5. The clock has been relocated to the adjacent wall to facilitate viewing from the inside of the Extra Care Suite 6. A method of providing a seamless wall construction is currently being developed and will be completed subject to funding and availability of the suite to have the works completed.

Area for Improvement No. 4 **Ref:** Quality Standard 5.3.3 (f) **Stated:** Second time **To be completed by:** 15 September 2017	<u>Psychology and behaviour support services</u> There was no psychological care / intervention plans 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 or 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 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.
	Response by responsible individual detailing the actions taken: The Multidisciplinary Team will be supporting the Behavioural/ Psychology service to identify which patients need a Behavioural Support Plan. A Behaviour Support Plan template review is in progress. The service improvement issues identified regarding assessments, formulation, and both behavioural and intervention plans will be addressed by integrating the Behaviour Support worker and the Psychology resources together to ensure appropriate supervision and accountability mechanisms are in place. A comprehensive review of all materials and measures involved in the process of assessment, formulation, and intervention will be conducted to ensure a more inclusive and standardised procedure is put in place that supports the principles of person-centred care. Once the new materials and procedures are established training will be provided to the ward staff on how to use, interpret, and support the various outcomes identified as part of the person centred intervention plan (including proactive supports for challenging behaviours)

Area for Improvement No. 5 **Ref:** Quality Standard 5.3.3 (f) Stated: Second time **To be completed by:** 15 September 2017	<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 patients' 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 records that were out of date and non-essential information contained in each patient's care documentation. This made it difficult to review the patients' 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.
	Response by responsible individual detailing the actions taken: Medical Staff are currently completing Medical Summaries. All inpatients will have a summary and formulation by the end of June 2017. The ward round MDT template has been reviewed. MDT staff are completing the respective sections of the template for each patient. The Ward Sister will conduct an audit of the template and adherence to completion. All outdated and non-essential information has been removed from the current patient care documentation and archived separately. The therapeutic meetings, which will include the Psychologist Behaviour Support Nurse and OT, will be the fora for development of Behaviour Support plans. They will communicate and share their assessments and intervention plans in a much more transparent way that is accessible and supported by the team. This will link in with the MD Team through Psychology staff attending in person.
Area for Improvement No. 6	<u>Governance overview of incidents</u>

Ref: Quality Standard 5.3.2 **Stated:** Second time **To be completed by:** 15 June 2017	There were 676 incidents recorded between 1 April 2015 – 31 March 2016. Inspectors reviewed the incidents recorded since the last inspection in July 2016. There were 553 recorded incidents on the DATIX system. 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.
	Response by responsible individual detailing the actions taken: The Clinical & Social Care Governance Coordinator MH&D has met with the Ward Sister to revise the current information/trends provided on the Dashboard. Incidents are discussed at the weekly MDT meeting and also discussed at Dorsy Governance Meeting. The trends and patterns will be discussed and details of any action taken as a result of the review. The frequency and use of restrictive practices continue to be reviewed by the ward and the results of this will be shared at the Governance meeting for oversight and review. Each incident will have been reviewed by the Ward sister to sign off. Her Dashboard will give her an overview of the incidents and she will match these against the interventions put in place to reduce the likelihood of these reoccurring. The Ward staff have received training in Positive Behaviour Support and are working to embed it into their daily work. The OT plans activities both on an individual and Group basis to provide an environment suitable to the needs of the patient population
Area for improvement No. 7 **Ref**: Quality Standard 5.3.1 (e) **Stated:** First time **To be completed by:** 15 September 2017	<u>Extra Care suite (this area is used for seclusion)</u> Inspectors noted that there was an area in the court yard that could not be viewed by the CCTV camera. Staff were not aware of this, so this was not reported to the estates department for repair. This area is known by the ward as an extra care suite. However this area does not meet the standard in relation to meeting all the daily living needs of a patient, as it does not include a sitting room with safe furnishings. Inspectors remain unclear how a room where the only furnishing provided is a mattress on the floor could be considered as an extra care suite.
	Response by responsible individual detailing the actions taken: There is now in place daily monitoring of the cameras for this area

	and any faults are reported to Estates. The contract allows for this to be dealt with same day. Any delay in response from Estates will be escalated immediately to Line manager. The Ward Sister and members of the MDT have planned to visit other facilities to explore best practice/initiatives pertaining to this aspect of care. The Trust is reviewing this area and has arranged to visit other units.
Area for improvement No. 8 **Ref**: Quality Standard 5.3.3 (f) **Stated:** First time **To be completed by:** 15 September 2017	<u>Psychology service</u> There were two part time associate psychologists working on the ward. The associate psychologists were based in the community. The consultant clinical psychologist indicated that they do not see any patients but attended the therapeutic meetings one half day per week. The associate psychologists stated they were asked to work beyond their role and remit and could not provide interventions to meet the assessed needs of the patients as they were not trained to do so. Care and treatment was therefore not provided in accordance with NICE Guidelines (Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges May 2015). Patients did not have access to any evidenced based psychological therapies, for example: psychosis, trauma, anger management, attachment, obsessive compulsive disorder, autism or forensics. Patients with forensic requirements did not access care despite the consultant clinical psychologist being dual qualified as a forensic psychologist.
	Response by responsible individual detailing the actions taken: A comprehensive review of the Psychology input will be conducted by the Head of Psychology services to include the role, responsibilities, and workforce requirements of the unit. The review will also need to address the Professional governance, supervision and clinical leadership provided within the unit and will ensure a standardised approach to all aspects of assessment and intervention planning to include, where appropriate both behavioural management and access to more therapeutic interventions. All recommendations and subsequent actions required will be shared with Senior management by end of June 2017.

Area for improvement No. 9 **Ref**: Quality Standard 5.3.3 (f) **Stated:** First time **To be completed by:** DD Month Year	<u>Model of care</u> Inspectors could not determine what model of care was used to underpin this service. Inspectors recommend that training needs analysis and work force review is completed following the trust's decision on the model of care.
	Response by responsible individual detailing the actions taken: Due to the diverse and complex nature of the presentation of patients admitted to Dorsy it is difficult to adapt a specific model, however, for those patients who present with behaviour that challenges, a Positive Behaviour Support Model is appropriate to underpin their care. There has been training provided in the area of Positive Behaviour Support. For all patients the MDT will apply the biopsychosocial model of care that will be person-centred and recovery focussed.
Area for improvement No. 10 **Ref**: Quality Standard 5.3.3 (f) **Stated:** First time **To be completed by:** 15 June 2017	<u>Recording and storage of patient's records</u> Inspectors were informed that behaviour support records were locked in the behaviour support service drawer. Inspectors were concerned that no one could access these records in the absence of the behaviour support nurse. Inspectors reviewed the psychology records retained in the locked psychology cabinet; these were old community files. Inspectors noted that these records did not meet legal or professional standards. Records were not always dated, the wrong date was recorded on one occasion (i.e. the patient's date of birth rather than the date of the assessment) and there were gaps in the progress notes. The consultant clinical psychologist confirmed that there was no governance oversight of the records.
	Response by responsible individual detailing the actions taken: All patient records are accessible to all staff working in Dorsy in accordance with MHD Guidance on Sharing Information for Direct Patient Care. An audit of the existing community psychology files has now been completed and identified that there were a small number of incorrect historical entries from 2003/2004 where dates or signatures where not provided. A review of the latest psychology entries in both the MDT and community files indicated that all information was compliant with professional and legal standards. A regular review of the psychology entries and recordings will now be incorporated into a rolling audit cycle to be completed by the Lead Psychologist to ensure ongoing standards are monitored and maintained.

	Comment Ivor
Area for improvement No. 11 **Ref**: Quality Standard 5.3.1(e) **Stated:** First time **To be completed by:** 15 May 2017	<u>Environment</u> Inspectors noted on review of the incidents that the exit door beside the extra care suite was broken and reported to the trust estates department on 13 February 2017. The door remained unsecure. It was noted that a patient on enhanced observations had absconded through the same door. There was no evidence that the delay in carrying out this remedial work was recorded on the ward risk register.
	Response by responsible individual detailing the actions taken: The Ward Risk Register has been reviewed and updated. The door has been repaired but requires replacement parts to be fitted. These are currently on order and will be fitted as soon as they are delivered. Following the inspection we met with Estates senior managers and we now have a dedicated Senior estates officer linking with Bluestone

Name of registered manager/person completing the PCP	Geraldine Dinsmore		
Signature of registered manager/person completing the PCP		**Date completed**	1.5.2017
Name of responsible individual approving the PCP	Bryce McMurray		
Signature of responsible individual approving the PCP		**Date approved**	9.5.17
Name of RQIA inspector assessing response	Wendy McGregor		
Signature of RQIA inspector assessing response		**Date approved**	11 May 2017

Please ensure this document is completed in full and returned to MHLD.DutyRota@RQIA.org.uk from the authorised email address

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews