The Regulation and Quality Improvement Authority

RQIA

Mental Health and Learning Disability

Unannounced Inspection

Ward K, Mater Hospital

Belfast Health and Social Care Trust

2 and 3 December 2014

national preventive mechanism

informing and improving health and social care

www.rqia.org.uk

Contents

1.0 General Information

Ward Name	Ward K, Mater Hospital
Trust	Belfast Health and Social Care Trust
Hospital Address	45-51 Crumlin Road Belfast BT14 6AB
Ward Telephone number	028 95041421/95041422
Ward Manager	Noel Burke
Email address	Noel.burke@belfasttrust.hscni.net
Person in charge on day of inspection	Noel Burke
Category of Care	Mental health
Date of last inspection and inspection type	29 May 2013
Name of inspector(s)	Alan Guthrie Nicola Rooney

2.0 Ward profile

Ward K is a 20 bedded ward that provides treatment and care for male patients with a mental illness who require assessment and treatment in an inpatient setting. The ward is one of three acute psychiatric wards occupying an old Victorian building on the Mater hospital site. Ward K is on the second floor of the building.

Patients on ward K are supported by nursing, medical, occupational therapy, social work and hotel staff. On the days of the inspection all of the beds were occupied and four patients had been admitted to the ward in accordance to the Mental Health (Northern Ireland) Order 1986.

3.0 Introduction

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

3.1 Purpose and Aim of the Inspection

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

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

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

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

3.2 Methodology

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

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

The inspection process has three key parts; self-assessment, pre-inspection analysis and the visit undertaken by the inspector. Specific methods/processes used in this inspection include the following:

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

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

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

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

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

4.0 Review of action plans/progress

An unannounced inspection of Ward K was undertaken on 2 and 3 December 2014.

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

The recommendations made following the last announced inspection on 29 May 2013 were evaluated. The inspector was pleased to note that 15 of the 16 recommendations had been fully met and compliance had been achieved in the following areas:

- patients' attendance at the multi-disciplinary ward round was documented;
- arrangements and accountability for cleaning of the smoking area had been clarified and were being adhered to;
- staff had received training, appropriate to their role, in the Trust's new adult safeguarding procedures and appropriate records had been maintained;
- patient care records had been regularly audited and records of the audits had been maintained;
- occupational therapy and social work notes were recorded and captured for each patient on ward K's CIS system;
- the door buzzer alert system and the public announcement had been reviewed;
- patients had individual patient activity plans detailing their daily and weekly activity and therapeutic timetable;
- the procedures regarding the safety of patient's property had been reviewed;
- information regarding the responsible manager/designated officer had been shared with all staff and the information was displayed on a flow chart in the ward's main office;
- information regarding the rights of patients detained under the Mental Health (NI) Order 1986 was available in easy read format;
- occupational therapy assessments were offered, were required, to patients during the initial assessment;
- staff had been made aware of the role of the ward manager and the responsible manager/designated officer in relation to the reporting of incidents, accidents and serious adverse incidents. The identity of the nominated manager/designated officer had been shared with all staff;
- ward K's layout had been reviewed and consideration was given to increasing the number of side rooms within the ward to facilitate more privacy for patients and greater opportunity to access quiet spaces;
- therapeutic and leisure equipment available for patients on ward K was properly maintained;
- guidance regarding the management of illicit substance misuse in acute mental health inpatient services was available to all staff.

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

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

The recommendations made following the finance inspection on 30 December 2014 were evaluated. The inspector was pleased to note that two recommendations had been fully met and compliance had been achieved in the following areas:

- ward manager retained appropriate information and detail of patient property retained by the ward;
- the Trust had introduced a uniform policy for managing patients' finances across all wards.

5.0 Inspection Summary

Since the last inspection the ward had addressed a number of previous recommendations and implemented a number of positive changes. These have included enhancing patient involvement in their care and treatment, providing information to patients in easy read format, increasing the availability of recreational and therapeutic activities and ensuring that the ward's outside spaces remained cleaned and properly maintained.

The following is a summary of the inspection findings in relation to the Human Rights indicator of Autonomy and represents the position on the ward on the days of the inspection.

Inspectors reviewed five sets of patient care documentation. Inspectors evidenced that on admission a checklist was completed with each patient to ensure that the patient was appropriately admitted to the ward and that they received an assessment, risk assessment and care plan. The checklist also recorded that patients should be assessed by a nurse and a doctor. The checklist directed staff to verify that patients and their relative/carer were introduced to the ward and its environment and that they received information regarding their rights, the ward's procedures and what patients should expect during their admission. Patients who met with inspectors reflected positively about their experience of ward staff and of the care and treatment they had received during their admission.

Inspectors reviewed the ward's procedures for assessing patient capacity to consent to their care and treatment and the plan used for supporting a patient who had been assessed as lacking capacity. Inspectors noted the ward's procedures to be appropriate and in accordance to regional guidance. Inspectors were informed that in circumstances where a patient lacked capacity the patient's progress was reviewed daily and decisions regarding the patient's care and treatment were taken by the multi-disciplinary team in consultation with the patient's relative/carer. Patient care documentation

reviewed by inspectors evidenced that staff continually updated and involved patients in decision making regarding the patient's care and treatment.

Inspectors evidenced that patient care records were comprehensive and up to date. The ward retained patient records in both paper and electronic copy. It was positive to note that all staff within the multi-disciplinary team updated patient continuous care notes on the Trust's PARIS patient information system. Inspectors were informed that the Trust was continuing to develop the system and that patient assessments, risk assessments and care plans would be transferred from paper copy to the PARIS system by 31 March 2015.

Patients and staff who met with inspectors reflected positively on the ward's therapeutic and recreational activities programme. Patient involvement in activities was documented in an individual activity plan and patients could participate in activities inside and outside the ward. The activities available to patients were noted to be varied and accessible on a daily basis. The facility's fitness and oasis rooms were reviewed by inspectors. Both rooms were well equipped and accessible to patients daily Monday to Friday, on certain evenings and at the weekend. It was positive to note that the facility had appointed a permanent member of staff to oversee activities provided within the oasis room.

The ward's occupational therapist (OT), group therapist and psychologist provided therapeutic interventions on a 1 to 1 and group work basis. Patient involvement in these interventions was recorded on individual person centred plans. Nursing staff who met with the inspector reflected that these services were responsive and supportive to patients. Staff informed inspectors that they found the services to be responsive and beneficial to patients. Inspectors discuss the provision of these services with the ward's OT, psychologist and group therapist. All three practitioners reflected positive experiences of multi-disciplinary structures within the ward.

Inspectors noted that the ward provided a broad range of information, relevant to patients, which was displayed on the ward's notice boards. This included details of external support services that patients could access. Inspectors noted posters regarding the availability of independent advocacy services and an independent legal advice service. The ward's patient admission template included a section to ensure patients and their relative/carer had been given a ward information booklet and that they were provided with details about their rights. Information regarding patient and relative/carer rights was also available on the ward's main notice board. Patients admitted to the ward in accordance to the Mental Health (Northern Ireland) Order 1986 (The Order) were provided with information regarding their right to challenge their admission through the Mental Health Review Tribunal. It was good to note that this information was available in easy read format.

Inspectors reviewed the ward's processes and procedures for the management of restrictive practices used with patients. Restrictive practices used appropriately within the ward included monitored access to the ward, the removal of sharp items, the use of observation and use of physical

intervention. The ward's main entrance door was locked from the outside and could be opened from the inside. Subsequently, patients were not locked inside the ward. The door had a loud buzzer system that alerted staff when the door was opened from the inside without staff knowledge. Inspectors felt that this system helped to keep patients safe whilst promoting a least restrictive practice environment as the door remained open to patients.

Inspectors reviewed the ward's processes and procedures in relation to patient observations. Inspectors evidenced that staff completed observations in accordance to Trust policy and procedure. Inspectors met with three patients who had received observations during their admission. Patients reported that the reason why observation was being used had been explained to them and that staff had been "nice", "respectful" and "fair" during their observations.

Records relating to the use of restraint were completed on a managing actual and potential aggression (MAPA) intervention form on the Trust's DATIX system and recorded as an incident through the Trust's incident reporting procedures. Inspectors reviewed the ward's processes for the management of physical intervention and noted that the ward's training records reported that as of November 2014 72% of staff had completed up to date MAPA training. Inspectors discussed this with the ward manager and reviewed the wards training records for each member of the nursing staff team. Inspectors were satisfied that the ward manager had taken appropriate action to ensure that the remaining 28% of staff competed training at the nearest opportunity. Inspectors noted that training for four members of staff had lapsed within the previous four weeks. Nursing staff supervision records were also reported on the ward's training records. Inspectors evidenced a number of deficits in relation to nursing staff completing the required level of supervision. A recommendation previously made regarding this issue has been restated for a second time. Supervision records for other members of the multi-disciplinary team were retained by their professional lead. However, inspectors were assured by the ward manager that they could access the records as required. Non nursing staff from the multi-disciplinary team who met with inspectors reported no concerns regarding their ability to access supervision.

The ward's arrangements for discharge were discussed with each patient on admission. The patient information booklet detailed that the ward worked in partnership with a range of voluntary, community and statutory mental health services to support patient recovery and limit the time spent in hospital. Patients who met with inspectors demonstrated awareness regarding the ward's discharge procedures. Patient discharge plans reviewed by inspectors were noted to be appropriate and to evidence patient involvement in their discharge. It was positive to note that a patient's discharge plan was supported by the Trust's Home Treatment Team and the ward' s social work and occupational therapy staff.

Details of the above findings are included in Appendix 2.

On this occasion ward K has achieved an overall compliance level of compliant in relation to the Human Rights inspection theme of "Autonomy".

6.0 Consultation processes

During the course of the inspection, the inspector was able to meet with:

Patients	six
Ward Staff	seven
Relatives	none
Other Ward Professionals	none
Advocates	none

Patients

Patients who met with inspectors were complimentary regarding the care and treatment they had received on the ward. Patients were positive about their ability to access staff support and the availability of the oasis room. Each patient reported that they had been given the opportunity to be involved in their care and treatment. Patients also reflected that they felt safe on the ward. Patient comments included:

“I have been treated fairly”;

“Staff were respectful” (during observations);

“Very nice staff”;

“Nursing staff are more than good”;

“I can speak to the doctor and nursing staff when I want”;

“I like the staff they’re good”;

“Teas are nice”.

Relatives/Carers

No relatives/carers were available to meet with the inspector during the inspection.

Ward Staff

Inspectors met with five members of the ward’s multi-disciplinary team (MDT) including a student nurse who was on placement. The student nurse informed inspectors that they had found the staff very helpful towards patients and the relationships within the MDT were “really good”. Nursing staff reported that they felt supported by their line management and that their views and opinions

were acknowledged. The ward's occupational therapist and psychologist reflected positively on their experiences of working in the ward and on the support and integration within the MDT. Staff comments included:

"I'm listened to";

"Good atmosphere on the ward";

"Patients spend time with Doctors and nursing staff";

"Staff are very helpful to patients and other staff";

"Great working here".

Other Ward Professionals

No other ward staff professionals were available to meet with the inspector during the inspection.

Advocates

None of the advocates were available to meet with the inspector during the inspection.

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

Questionnaires issued to	Number issued	Number returned
Ward Staff	20	7
Other Ward Professionals	2	1
Relatives/carers	20	0

Ward Staff

Seven nursing staff and a social worker returned questionnaires prior to the inspection. All staff reported awareness of the restrictive practices implemented on the ward. However, seven staff reported that they were not aware of the deprivation of liberty safeguards. Staff listed restrictive practices to include: patients accompanied time off the ward, patients remaining ward based, escorted smokes, 1:1 observations, use of restraint and use of the Mental Health (Northern Ireland) Order 1986. All staff documented that they felt patients on the ward could access therapeutic and recreational activities and activities were designed to meet patient's individual needs. Additional comments made by staff included:

"Current staff do a very good job on limited resources";

“Patients cannot always access therapeutic and recreational programmes due to mental health, choice or restrictions”;

“Need more facilities for physical exercise”;

“The ward staff are highly committed to their job but the environment of the ward is very poor”;

“There is a serious lack of space to give patients areas to effectively relax or to nurse patients in a state of high distress”;

“Nursing and occupational therapy staff are very proactive in attempting to provide support to patients tailored to the patient’s needs”.

Inspectors discussed the availability of space to support patients in a state of distress with the ward manager. The ward had two large side rooms which patients and staff could use as required. The ward manager relayed that the ward’s dining area was also available.

Other Ward Professionals

No other ward professionals returned questionnaires.

Relatives/carers

No questionnaires were returned by relatives/carers prior to the inspection.

Inspectors discussed the ward’s policies and procedures for the use of restrictive practices with staff. Staff demonstrated appropriate knowledge and understanding of the use of restrictive practice including the impact the use of restrictions had on patients’ rights. Inspectors were concerned that staff questionnaires recorded that seven staff did not have awareness of the Deprivation of Liberty Safeguarding (DOLS) Interim Guidance. A recommendation has been made.

7.0 Additional matters examined/additional concerns noted

No additional matters were examined/additional concerns noted during the inspection.

Complaints

Inspectors reviewed the ward’s complaints records during the inspection. Inspectors noted that the last complaint received on the ward was recorded on the 17 November 2014. The complaint had been recorded and managed in accordance to Trust policy and procedure. Complaints reviewed by inspectors were noted to include a description of the complaint, the action taken and the outcome. All of the complaints had been resolved to the satisfaction/partial satisfaction of the complainant.

8.0 RQIA Compliance Scale Guidance

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

Appendix 1 – Follow up on Previous Recommendations

The details of follow up on previously made recommendations contained within this report are an electronic copy. If you require a hard copy of this information please contact the RQIA Mental Health and Learning Disability Team:

Appendix 2 – Inspection Findings

The Inspection Findings contained within this report is an electronic copy. If you require a hard copy of this information please contact the RQIA Mental Health and Learning Disability Team:

Contact Details
Telephone: 028 90517500
Email: Team.MentalHealth@rqia.org.uk

Follow-up on restated recommendations following the announced inspection on 25 and 26 January 2011

No.	Recommendations	Number of times stated	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	It is recommended that patients' attendance at the multi-disciplinary ward round is documented accordingly.	2	The ward was supported by two consultant psychiatrists. Subsequently, two multi-disciplinary team (MDT) meetings were convened each week. Patient care documentation reviewed by inspectors evidenced that some patients attended meetings on a regular basis, whilst other patients did not attend. Inspectors were informed that patients who did not attend the MDT meeting could do so upon request. Patients who spoke with inspectors reported that they met with nursing staff and their consultant psychiatrist on a regular basis and that they were involved in their treatment and care plan reviews. Patients reported no concerns regarding their ability to attend the MDT meeting.	Fully Met
2	It is recommended that arrangements and accountability for cleaning of the smoking area are clarified, monitored and adhered to.	2	Patients on ward K could smoke in the wards outside area, located in the central area of the ward, and at the entrance to the facility. Inspectors were informed that the ward's smoking areas were cleaned three times each week by staff from estate services. Inspectors reviewed the smoking areas and noted these to be clean and maintained.	Fully Met

Follow-up on recommendations made following the announced inspection on 29 May 2013

No.	Reference.	Recommendations	Number of times stated	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	18	It is recommended that all staff receive training, appropriate to their role, in the Trust's new adult safeguarding procedures. Accurate and up to date training records should be held on the ward for each member of staff.	1	Inspectors reviewed the ward's training records and noted that 23 of the ward's 25 nursing staff had completed vulnerable adults training in accordance to regional and Trust guidelines. Guidelines stipulated that vulnerable adults' training was required to be completed once every three years and inspectors noted that two members of staff had not completed update training. Inspectors were informed that both members of staff were on continued night duty and future dates for update training had been arranged for them and would take place in February 2015.	Fully Met
2	20	It is recommended that the ward manager develops a system of regular audit of patient care records and maintains relevant records.	1	Inspectors evidenced that patient care records were audited on a regular basis. Audits assessed by inspectors were noted to be comprehensive and to review of all aspects of a patient's care and treatment journey including the patient's admission, care planning and discharge.	Fully Met
3	20	It is recommended that all records including occupational therapy and social work notes are recorded and captured for each patient on Ward K's CIS system to ensure contemporaneous records	1	Patient care documentation retained on the Trust's PARIS patient information system included each patient's continuing care records and Health of the Nation Outcome scale (HONOS) which was completed with each patient. Inspectors noted that occupational therapy and social work notes were available on the system. Patient assessments, risk assessments and care plans were retained on paper copy.	Fully Met

		of patient contact and progress.		Inspectors were informed that the plan to ensure that all patient care records were recorded and maintained on the Trust's PARIS system had been delayed due to problems with the procurement and redesign of the required computer software programme. Inspectors were further informed that the new programme was now ready and the Trust had set a deadline for all patient care documentation, relevant to the patient's care and treatment received from the Trust's mental health services, would be available on the PARIS system by the 31 March 2015. Inspectors assessed that this recommendation was not completed due to circumstances beyond the Trust's control. Subsequently, the recommendation will not be restated for a second time. A new recommendation reflecting the deadline set for the transfer of patient information has been made and can be found in the quality improvement plan accompanying this report.	
4	17	It is recommended that Ward K's door buzzer alert system and the public announcement system be reviewed and consideration be given to introducing a system which could reduce noise and disruption to the ward.	1	The ward's public announcement system and door buzzer alert system had been reviewed. The public announcement system had been turned off as it had been assessed as no longer necessary. The ward's buzzer system remained in place. Inspectors reviewed the system and noted that it was loud. However, the system supported the ward's least restrictive practice ethos as it enabled staff to monitor individuals leaving the ward whilst ensuring that the	Fully Met

				door remained open at all times. The buzzer was only activated when the door was opened from inside the ward without the use of a key fob or without support from a member of staff. Inspectors felt that although the buzzer system was potentially disruptive because of the noise generated, when the door was opened from inside the ward without permission, the disruption was felt to be acceptable. Inspectors based this determination on the fact that during the inspection the buzzer was activated infrequently and the system ensured that the door remained unlocked. This protected patient's rights and supported the ward's least restrictive practice ethos.	
5	13	It is recommended that patients have individual patient activity plans detailing their daily and weekly activity and therapeutic timetable.	1	Patient involvement in daily, weekly and therapeutic activities was detailed in patient care documentation reviewed by inspectors. The ward provided a range of activities, on a daily basis, that patients could choose to attend. Patient care documentation reviewed by inspectors evidenced that patient involvement in occupational therapy, psychology and green gym activities (gardening activities away from the ward) was recorded on individual patient activity plans. Patient involvement in activities was also recorded in patient care plans and within patient continuous care and progress records.	Fully Met
6	13	It was recommended that internet access is made available within the Oasis resource.	1	Internet access was not available in the facilities Oasis room. Inspectors were informed that the availability of internet access within the Oasis room had been delayed due to concerns regarding security and	Not Met

				systems management concerns. Inspectors were further informed that the Trust had set a deadline to ensure that internet access was available within the Oasis room by the 31 March 2015. This recommendation will be restated.	
7	8	It is recommended that Ward K review its procedures regarding the safety of patient's property.	1	Inspectors reviewed the ward's procedures for ensuring the safety of patient's property. Inspectors noted the procedures to be in accordance with Trust and regional guidelines. Patients could access a personal safe and patient property retained by the ward had been appropriately managed, recorded and documented by ward staff.	Fully Met
8	20	It is recommended that all staff receive professional supervision in accordance with Trust and professional standards and requirements.	1	Records detailing the supervision and appraisal of nursing staff were reviewed by inspectors. Records evidenced that ten nursing staff had completed two supervision sessions since January 2014, six staff had completed one supervision session and nine staff had received no supervision. Inspectors discussed this with the ward manager and members of the senior management team. Inspectors were informed that the ward had experienced managerial changes during the previous five months and this had affected the provision of staff supervision sessions. It was good to note that the ward manager had taken steps to address this issue and that future supervision sessions had been booked and recorded for each member of the nursing staff team. Inspectors met with the ward's psychologist,	Not Met

				occupational therapist, four nursing staff and a student nurse. Staff who met with the inspectors reported no concerns regarding their ability to access supervision and appraisal. Supervision records for other members of the multi-disciplinary team were retained by their professional lead.	
9	19	It is recommended that information regarding the responsible manager/designated officer is shared with staff in Ward K. This information should be displayed on a flow chart in the ward's main office.	1	Information, including a flowchart, detailing the protection of vulnerable adults (POVA) referral procedure and the names of the responsible manager and designated officer was available in the ward's main office. Professional staff who met with the inspector demonstrated appropriate understanding and knowledge of the ward's POVA policy and procedure.	Fully Met
10	11	It is recommended that Ward K introduce information regarding the rights of patients detained under the Mental Health (NI) Order 1986 in easy read format.	1	Information regarding the rights of patients admitted to hospital in accordance to the Mental Health (Northern Ireland) Order 1986 was available in easy read format. The information included guidance on patients' rights to contact the Mental Health Review Tribunal.	Fully Met
11	13	It is recommended that the process of referring a patient to the ward's OT be reviewed and that consideration is given to the inclusion of OT assessment during the initial assessment of a patient.	1	Inspectors reviewed the ward's occupational (OT) therapy service and met with the ward's OT. The OT explained that they met with each newly admitted patient to discuss the patient's needs and ascertain the patient's view regarding involvement in OT activities. Comprehensive OT assessments were completed as required and upon request from patients and or ward staff.	Fully Met

				Nursing and other professional ward staff who met with the inspectors reported no concerns regarding their ability to refer a patient to the OT service.	
12	18	It is recommended that staff are made aware of the role of the ward manager and the responsible manager/designated officer in relation to the reporting of incidents, accidents and serious adverse incidents. The identity of the nominated manager/designated officer is shared with all staff.	1	Inspectors reviewed the ward's policies and procedures in relation to the management of incidents, accidents and serious adverse incidents. Copies of the Trusts adverse incident reporting and management policy and reporting guidelines were available on the Trust's policy sharing computer database that all staff could access. Information detailing the protection of vulnerable adults' referral procedure including the names of the responsible manager and designated officer was available in the ward's main office. Staff who met with inspectors demonstrated appropriate understanding and knowledge of their role in management and reporting of accidents, incidents and serious adverse incidents.	Fully Met
13	8	It was recommended that Ward K's layout is reviewed in light of decreasing bed numbers within the acute inpatient services. Consideration should be given to increasing the number of side rooms	1	Ward K's layout had been reviewed and consideration had been given to reducing the numbers of beds available on the ward and to utilise the remaining space to improve privacy for patients. The review was conducted on each of the three wards within the facility. However, ward K's layout remained unchanged as the Trust had assessed that there was ongoing need for the 20 beds that the ward provided.	Fully Met

		within the ward to facilitate more privacy for patients and greater opportunity to access quiet spaces.		The ward provided three rooms where patients could access quiet space. Patients could also attend the facilities Oasis room and gym. Inspectors were informed that there were currently no plans to review the ward's layout as the Trust's strategic and operational planning included the building and introduction of a new purpose built mental health acute admission inpatient facility. Managers informed inspectors that the facility would be operational in early 2017.	
14	13	It was recommended that therapeutic and leisure equipment available for patients on Ward K is properly maintained and broken equipment replaced.	1	Inspectors reviewed the ward's leisure equipment, the occupational therapy room and the facility's gym and Oasis room. All of the equipment for patient use was noted to be properly maintained. Staff who met with inspectors reported no concerns regarding the maintenance or repair/replacement of equipment.	Fully Met
15	8	It was recommended that Ward K's bathroom and toilet areas be refurbished. This should include the replacing of burn marked flooring and the replacing of shower curtains.	1	The inspector reviewed the ward's bathroom and toilet areas and noted that burn marked flooring and shower curtains had been replaced. However, the rooms had not been fully refurbished. The inspector was informed that new resources had been recently secured and it was hoped that the bathroom and toilet areas would be updated.	Not Met
16	20	It was recommended that guidance regarding the management of illicit substance misuse in acute mental health inpatient	1	Guidance regarding the management of illicit substance misuse in acute mental health inpatient services was available on the Trust's shared policy database. The policy was noted to be up to date and to include a review date.	Fully Met

		services is made available to all staff.			

Appendix 1

Follow-up on recommendations made at the finance inspection on 30 December 2013

No.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	It is recommended that the ward manager ensures that a record of staff who access the key to the Bisley drawer, and the reason for access, is maintained.	Patients could retain their own valuables in their personal locked storage. The ward manager informed inspectors that they could access patient locked storage if necessary and with patient consent. In circumstances where a patient did not consent and staff remained concerned about potential risk to the patient or others this was reviewed by the multi-disciplinary team and a plan agreed. Inspectors were informed that previous plans had involved Police. Patient's money retained by ward staff was secured in the wards safe and details entered into the safe book. The safe was maintained and managed by the Trust's finance department. Inspectors reviewed the safe book and noted that this was managed in accordance to Trust policy. The ward did not use a Bisley drawer and this recommendation is no longer relevant.	Fully Met
2	It is recommended that the Trust introduce a uniform policy for managing patients' finances across all wards.	The Trust's 'Patient Finances and Private Property – Policy for Inpatients within Mental health and Learning Disability Hospitals' had been reviewed and was operational from March 2014.	Fully Met

Quality Improvement Plan

Unannounced Inspection

Ward K, Mater Hospital

2 and 3 December 2014

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

The specific actions set out in the Quality Improvement Plan were discussed with the ward manager, the service manager, the service manager acute mental health services, the assistant director of mental health services and the service improvement manager on the day of the inspection visit.

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

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
1	Section 5.3.3 (a)	It was recommended that internet access is made available within the Oasis resource.	2	6 June 2015	The Trust has accepted a proposal for a Trust wide rollout of patient wifi access via BT Open Zone . It is unknown when full rollout will take place. The Trust would confirm that it will not meet this recommendation within the set timescale. Most patients are currently able to access the internet via their mobile phones. Timeline clarified with the Trust on the 6 February 2015.
2	Section 4.3 (l)	It is recommended that all staff receive professional supervision in accordance with Trust and professional standards and requirements.	2	31 March 2015	All staff will have received one supervision session by the end of March 2015. A rolling plan of supervision sessions within Ward K is now in place.
3	Section 5.3.1 (f)	It was recommended that Ward K's bathroom and toilet areas be refurbished. This should include the replacing of burn marked flooring and the replacing of shower curtains.	2	31 March 2015	The issue of the flooring was addressed following the last inspection however this presents as a continuing problem due to the

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
					nature of the patient population. Given the current financial constraints, it is not possible to continuously replace the flooring. Consideration will be given to replacing the flooring when monies for refurbishment are made available. The issue of the shower curtain was addressed following the last inspection and staff do aim to replace the shower curtain each time it is taken down, however again this is a continuous problem due to the nature of the ward's patients. Although the shower curtain may not be in place at all times, patient dignity is still maintained by the locking of the bathroom door. The Charge Nurse will contact the Trust's Health and

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No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
					Safety Department to undertake a risk assessment regarding risks around shower curtains on the ward.
4	Section 5.3.3 (f)	It is recommended that the ward manager ensures that all ward staff are aware of the Deprivation of Liberty Safeguards (DOLS) – Interim Guidance (2010)	1	Immediate and ongoing	An email was sent by the Charge Nurse to all staff on 14 January 2015 in relation to Deprivation of Liberty. This included the Depreviation of Liberty Safeguards (DOLS) - Interim Guidance 2010, Deprivation of Liberty Safeguards – a Guide for Hospitals and Care Homes and guide to how deprivation of liberty can be identified. DOLS will also be discussed during staff meetings.

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

NAME OF WARD MANAGER COMPLETING QIP	Noel Burke
NAME OF CHIEF EXECUTIVE / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Martin Dillon

Inspector assessment of returned QIP				**Inspector**	**Date**
		Yes	**No**		
A.	Quality Improvement Plan response assessed by inspector as acceptable	x		Alan Guthrie	5 February 2015
B.	Further information requested from provider	x		Alan Guthrie	5 February 2015