The Regulation and Quality Improvement Authority

RQIA

Mental Health and Learning Disability

Unannounced Inspection

Ward L, Mater Hospital

Belfast Health and Social Care Trust

5 and 6 August 2014

national preventive mechanism

informing and improving health and social care

www.rqia.org.uk

Contents

1.0 General Information

Ward Name	Ward L, Mater Hospital
Trust	Belfast Health and Social Care Trust
Hospital Address	45-51 Crumlin Road Belfast BT14 6AB
Ward Telephone number	028 95041427
Ward Manager	Paul Magowan
Email address	paul.magowan@belfasttrust.hscni.net
Person in charge on day of inspection	Jonny Boyle
Category of Care	Adult mental health acute admissions ward
Date of last inspection and inspection type	6 June 2014, patient experience inspection
Name of inspector	Alan Guthrie

2.0 Ward profile

Ward L is a fourteen bedded acute psychiatric inpatient facility. It is one of three psychiatric inpatient units in the Mater Hospital located within a general hospital site. Ward L is a mixed gender ward providing care and treatment to patients over 65 years and to patients, from aged 18, admitted for treatment in accordance to the Mental Health (Northern Ireland) Order 1986. The ward is staffed by a multi-disciplinary team which includes medical, nursing, social work and occupational therapy staff. It is situated on the third floor of the psychiatric department and provides a combination of en suite single rooms and dormitory accommodation.

On the days of the inspection the ward was at full capacity and seven of the patients had been admitted in accordance with 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 announced inspection of Ward L, Mater Hospital was undertaken on 5 and 6 August 2014.

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

The three recommendations made following the last unannounced inspection on 31 July 2013 were evaluated. Despite assurances from the Trust, three recommendations had not been fully implemented, one recommendation had been partially met and two recommendations had not been met.

The inspector could find no evidence that the recommendations in relation to analysis of incidents by the multi-disciplinary team, Trust guidance regarding the admission of young people to the ward and the completion of regular ward team meetings had been implemented. These 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 patient experience interview inspection

The recommendation made following the patient experience interview inspection on 6 June 2014 was evaluated. Despite assurances from the Trust, the recommendation had not been fully implemented. The inspector was informed that patients on ward L could not access ward based psychology services as a psychologist was unavailable. This recommendation will require to be restated for a second time in the Quality Improvement Plan (QIP) accompanying this report.

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

The two recommendations made following the finance inspection in December 2013 were evaluated. The inspector was pleased to note that one of the recommendations had been fully met and compliance had been achieved in the following area:

- The Trust had ensured that a record of staff who had accessed the safe and the reason for access was maintained.

However, despite assurances from the Trust, one recommendation had not been fully implemented. On the days of the inspection the inspector was informed that the Trust had not introduced a uniform policy for managing patient finances across all wards. This recommendation will require to be restated for a second time in the Quality Improvement Plan (QIP) accompanying this report.

5.0 Inspection Summary

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.

Since the last inspection the ward's senior management team had agreed that the number of beds available within the ward would be reduced to 12 in the near future. The inspector was informed that two of the current single bedrooms would be used to provide more interview space to facilitate patient consultations and reviews. On the day of the inspection the ward was providing care and treatment to 14 patients.

Patients who met with the inspector reflected positively on the care and treatment they received from staff within ward L. Care documentation reviewed by the inspector evidenced that on admission patients underwent a comprehensive assessment which included an assessment of the patient's capacity to consent to their care and treatment. If a patient's mental state examination indicated that the patient lacked the capacity to make decisions, the patient's consultant psychiatrist then completed a capacity assessment using the mini mental state (MMSE) examination tool.

The inspector reviewed the ward's protocols and procedures for the management of patients assessed as not having capacity to make decisions. The inspector noted that the ward implemented appropriate procedures to ensure that the patients' circumstances were closely monitored to ensure that patients remained safe. Decisions regarding the care and treatment of a patient who lacked capacity were agreed by the multi-disciplinary team in consultation with the patient's relative/carer. Staff who met with the inspector demonstrated appropriate knowledge of the ward's procedures for managing patients who lacked the capacity to make decisions. Staff also relayed understanding of Trust and regional guidance.

Ward staff who met with the inspector reflected that they felt the ethos and purpose of ward L had changed during the previous twelve months. Staff explained that alongside providing care for patients aged 65 and over the ward also provided care to patients who had been admitted to hospital on an emergency basis in accordance to the Mental Health (Northern Ireland) Order 1986. Five members of staff indicated to the inspector that in circumstances where a patient was admitted on an emergency basis to the ward staff been tasked by a senior manager to identify which patient to move out of ward L to another ward to facilitate the newly admitted patient. Staff described circumstances to the inspector where they had provided their opinion that a transfer was not in a patient's best interests. Staff indicated that their professional opinion was not taken into consideration when a final decision was made by senior management to transfer a patient out of the ward. The inspector also found that staff were not clear as to the criteria for admission to ward L and there was no guidance regarding the internal transfer of patients. Recommendations have been made.

The inspector reviewed three sets of patient care documentation. Patient assessments were comprehensive and patient care plans identified and addressed the patient's physical, psychological, communication and treatment and care needs. However, two sets of patient care information contained records that were incomplete. The inspector evidenced that one patient's induction and admission checklists had not been completed. A second patient's records also contained an incomplete induction checklist and the patient had not signed their care plan. Recommendations regarding the completion of patient records and the availability of patient signatures have been made.

Patient progress within ward L was monitored by nursing staff on a daily basis. Patients were also reviewed at the weekly multi-disciplinary team (MDT) meetings to which patients and where appropriate their relative/carer were invited to attend the weekly MDT meeting. The ward held four MDT meetings to facilitate the review of patients within ward L who were under the care of one of the four consultants. During the meetings each patient's care and treatment progress and discharge plan were reviewed. It was good to note that patients reported no concerns regarding the nursing, medical and occupational therapy support they received in ward L. Patients informed the inspector that they felt nursing staff were helpful and approachable and that they (patients) could meet with their consultant in private on a weekly basis. Patients also reported that they could attend their weekly review meeting and staff kept them informed regarding any changes to their care and treatment arrangements.

The ward's patient information booklet outlined the activities available to patients in ward L. On admission each patient was offered and occupational therapy (OT) assessment as part of their assessment and treatment programme. Ward L's OT had recently left their post and a new OT had been appointed. During the temporary absence of the OT patients on ward L were supported by the OT staff from the facilities' other two wards.

On the days of the inspection the inspector was informed that patients in ward L could not currently access input from the Trust's psychology services. In a previous patient experience inspection completed on the 6 June 2014 the inspector was advised that a new psychologist had been appointed and would be taking up post 'in the next few weeks' and a further psychologist would be returning from long term leave on the 7 July 2014. The recommendation made during the inspection in June 2014 will be restated for a second time.

Independent advocate support was available to patients upon request. Contact information regarding ward L's advocate service was available on two of the ward's notice boards. The inspector was informed that the advocate would attend the ward when requested.

The inspector reviewed the use of restrictive practices within ward L. The ward promoted a least restrictive intervention ethos and the inspector noted that where restrictions had been used with patients these had been individually assessed and implemented in accordance to Trust and regional

guidance. Copies of the Trust's observation and restraint policies and procedures were also available.

The patient information booklet included sections describing the arrangements for a patient's discharge and the importance of home leave to assist the patient in working towards returning home as soon as possible. Discharge planning for each patient was reviewed and discussed at the patient's weekly multi-disciplinary care review meeting. The patient and their relative/carer were invited to attend the meeting. The patient's consultant, the ward manager/charge nurse, the patient's named nurse, the ward's social worker, the ward's occupational therapist and a member of the crisis response and home treatment team were also invited to attend. The inspector was informed that one patient's discharge had been delayed and this had been reported to Health and Social Care Board. The patient remained under review and suitable accommodation had been identified and was being prepared for the patient's arrival.

Details of the above findings are included in Appendix 2.

RQIA received information on 24 February 2014 from a member of staff in ward L. The member of staff raised a number of issues, including concerns relating to serious adverse incidents, incident reporting, patient safety issues, and bed management. In correspondence to RQIA dated 25 March 2014, the Trust agreed to investigate the whistleblower's allegations under the Trust's whistleblowing policy and procedures. RQIA received the final investigation report of the whistleblowing allegation on 19 June 2014. Some aspects of the report findings were reviewed during the inspection.

On this occasion ward L has achieved an overall compliance level of moving towards compliance 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	Five
Ward Staff	Five
Relatives	None
Other Ward Professionals	None
Advocates	None

Patients

Patients who met with the inspector were complimentary about their relationships with staff and the care and treatment they received in ward L. However, patients informed the inspector that they remained concerned that they might have to move from ward L. Three of the patients explained to the inspector they were unhappy at having been moved from ward L to other wards within the facility. Recommendations have been made in relation to this. Patient comments included:

“Staff are very nice”;

“I went unwilling to ward #...moving people around is shaking patients up”;

“Staff were good…caring”;

“Request to move came out of the blue”;

“I get to see my Doctor and I am involved in my care and treatment”;

“I felt the move was awful. I’m scared of the patients here…I was hysterical last night”.

Relatives/Carers

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

Ward Staff

Ward staff who met with the inspector expressed concern that the ward’s purpose and the criteria for admission were not clear. Staff reported that the ward environment was challenging and there had been a large increase in the numbers of patients being admitted, at short notice, in accordance to the

Mental Health (Northern Ireland) Order 1986. Staff informed the inspector this had resulted in increased numbers of patients being internally transferred to other wards in the facility. Staff described the internal transfer of patients as being difficult to manage for patients and staff. Recommendations have been made in relation to this. Staff comments included:

"Great team";

"Moving a patient from ward L at short notice feels awful";

"If a patient refuses to move the senior manager rings the ward and tells staff to pick someone to move";

"Staff are very supportive";

"Patients do consent (to move) after a number of discussions";

"It's not ideal to move patients";

"I would come to work in the morning and find patients had been moved";

"I feel absolutely terrible, I feel powerless for the patients…patients crying…falling out with a colleague".

Other Ward Professionals

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

Advocates

The ward's advocate was not 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	15	0
Other Ward Professionals	15	0
Relatives/carers	15	0

Ward Staff

No questionnaires were returned by ward staff.

Other Ward Professionals

No questionnaires were returned by other ward professionals.

Relatives/carers

No questionnaires were returned by relatives/carers.

7.0 Additional matters examined/additional concerns noted

Staff supervision

The inspector reviewed staff supervision records. These indicated that the most recent recorded date of supervision for one member of nursing staff was in May 2013. The last recorded dates of supervision for two registered nurses were noted as April 2013. The last recorded date of supervision for eight registered nurses was noted as 2012. A further eight registered nurses had no date for supervision recorded. The inspector was concerned that staff were not receiving supervision in accordance to Trust and professional standards. A recommendation has been made.

Complaints

The inspector reviewed the complaints received by the ward from 11 November 2013 to the 9 June 2014. Six complaints had been received during this period. Four complaints related to concerns about the ward environment and two complaints related to the food and nutrition available on the ward. All of the complaints had been addressed and all six complainants had been fully satisfied with the outcome.

Patient transfers

Patients and staff who met with the inspector reported a number of concerns regarding the ward. Three patients informed the inspector that they had been moved from ward L, at short notice, to facilitate the emergency admission of patients who were admitted to hospital in accordance to the Mental Health (Northern Ireland) Order 1986. All three patients stated that they had not wanted to transfer out of ward L. During the inspection the inspector noted that patients remained anxious that they may be moved from ward L at any time. The inspector was concerned that the transfer of patients was causing continued disruption and stress for patients. A recommendation has been made.

Independent investigation

The findings of the RQIA inspection on 5 and 6 August 2014 provide evidence that the issues raised by the whistleblower regarding bed management, a lack of meaningful supervision and regular team meetings are substantiated.

Due to the serious nature of these matters, concerns were drawn to the attention of the Belfast Health & Social Care Trust's Chief Executive, in line with RQIA's Escalation policy. A meeting with senior Trust representatives was held on 20 August 2014 to discuss the actions to be taken by the BHSCT to address these concerns. Senior Trust representatives gave assurances to RQIA that the areas of concern highlighted within this report would be addressed immediately.

8.0 RQIA Compliance Scale Guidance

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

Appendix 1

Follow-up on recommendations made following the unannounced inspection on 31 July 2013

No.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	It is recommended that the ward manager ensures that the minutes of MDT meetings reflect discussion and analysis of incidents.	The inspector reviewed three sets of multi-disciplinary team meeting minutes. There was no record to reflect discussion and analysis of incidents. The inspector noted that three incidents had been reported between the 20 and 28 July 2014.	Not Met
2	It is recommended that Trust guidance regarding the admission protocol for young people in the care of the child and adolescent mental health services is reviewed and updated and is made available to all staff.	The inspector reviewed the Admission Protocol for Young People who are Admitted to Acute Adult Mental Wards Policy. The policy had not been updated. The inspector was informed that a new policy had been agreed and was in a review process with the Trust's governance department prior to its publication.	Not Met
3	It is recommended that team meetings for ward staff are held on a regular basis.	The inspector reviewed staff team meeting records. The last recorded team meeting had taken place on the 2 February 2011. Two members of nursing staff who met with the inspector reported that team meetings had previously been organised but had not taken place.	Not Met

Follow-up on recommendations made at the finance inspection on 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 safe and the reason for access, is maintained.	The ward's safe was managed by the Trust's finance department and could not be accessed by any member of ward staff. The safe was accessed by staff through a drop system that allowed staff to store items in it but not to access it. A finance officer attends the ward to remove safe contents at the request of ward staff.	Met
2	It is recommended that the Trust introduce a uniform policy for managing patients' finances across all wards.	A uniform policy for managing patients' finances across all wards was not available during the inspection. The Trust's finance department reported that the policy was not currently available.	Not Met

Follow-up on recommendations made following the patient experience interview inspection on 6 June 2014

No.	Reference.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	Section 5, 5.3.3 (f)	It is recommended that the Trust ensures that psychological services are available to patients on the ward.	The inspector was informed by the services manager that a psychologist had been appointed and was due to commence providing psychological treatment to patients on ward L on the 7 September 2014. The inspector was concerned that a previous commencement date agreed for the 7 July 2014 had not been met. On the days of the inspection, patients on the ward did not have access to psychology services.	Not Met

Quality Improvement Plan

Unannounced Inspection

Ward L, Mater Hospital

6 & 7 August 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 charge nurse, the services manager, the service improvement manager and the quality assurance 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.

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
1	5.3.1(a)	It is recommended that the ward manager ensures that the minutes of multi-disciplinary meetings reflect discussion and analysis of incidents.	2	Immediate and ongoing	The Charge Nurse, Ward L has now set up monthly multidisciplinary team meetings to look specifically at incidents occurring within the ward the previous month. Minutes of this meeting will reflect the discussions and analysis of incidents.
2	5.3.1(c)	It is recommended that Trust guidance regarding the admission protocol for young people in the care of the child and adolescent mental health services is reviewed and updated and is made available to all staff.	2	31 November 2014	This guidance has been reviewed and updated. It was circulated to all wards on 19 September 2014 and the ward is adhering to this. Please find attached copy of said guidance.
3	5.3.3(d)	It is recommended that team meetings for ward staff are held on a regular basis.	2	31 November 2014	Staff meetings take place on a regular basis.
4	4.3(f)	It is recommended that the Trust introduce a uniform policy for managing patients' finances across all wards	2	31 November 2014	This procedure was reviewed and circulated to all wards on 17 September 2014 and the ward is adhering to this. Please find attached copy of said procedure.
5	5.3.3(d)	It is recommended that the Trust ensures that psychological services are available to patients	2	Immediate and ongoing	A psychologist has recently taken up post and provides interventions across the three wards in Mater Hospital. The Hospital's Psychotherapist/

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
		on the ward.			Thorn Nurse has also returned from leave. They provide psychological services to patients.
6	5.3.3(b)	It is recommended that the Trust ensures that patients admitted to Ward L are not transferred from the ward without the patient's consent and the agreement of the multi-disciplinary team.	1	Immediate and ongoing	This has always been the position. Guidance has now been developed in relation to the transfer of patients within the acute mental health wards to address this. This guidance will be circulated to all releval personnel, week commencing 01 December 2014 following its ratification at the Mental Health Governance Meeting.
7	6.3.1(a)	It is recommended that the Trust ensures that guidance regarding the internal transfer arrangements of patients and the criteria of admission to each of the three wards within the facility is developed and implemented and made available to all staff.	1	31 November 2014	Please see above.
8	6.3.1(a)	It is recommended that the Trust ensures that guidance regarding the purpose of Ward L including the profile of the patients and the ward's aim and objectives is	1	31 December 2014	The Charge Nurse, Ward L is currently developing guidance in relation to the profile of patients in Ward L and the ward's aims and objectives. This will be completed and circulated to staff within said

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
		developed and made available to all staff.			timescale.
9	6.3.1(d)	It is recommended that the Trust ensures that guidance regarding the criteria for admission to ward L is developed and made available to all staff.	1	31 December 2014	Guidance has been developed in relation to the transfer of patients within the acute mental health wards to address this. This guidance will be circulated to all relevant personnel, week commencing 01 December 2014 following its ratification at the Mental Health Governance Meeting.
10	6.3.2(b)	It is recommended that the ward manager ensures that all patient care documentation is completed in accordance with the required standard. The ward manager should also ensure that patient signatures (or explanation for the absence of patient signature) are recorded where required.	1	Immediate and ongoing	Monthly audits of patient documentation are now undertaken by Band 6s in the ward. Any issues highlighted are then addressed with the staff member. An independent audit of patient documentation was undertaken by the Intern aligned to Mental Health Services in September, the results of which have been made available to staff.
11	5.3.3(d)	It is recommended that the Trust and the ward manager ensures that all staff working on the ward complete their mandatory training as required by the Trust.	1	31 January 2015	There is a rolling programme of training available to staff across mental health services to ensure they complete their mandatory training as per Trust Policy. The Charge Nurse, Ward L ensures that

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
					time is facilitated for staff to attend their mandatory training. A training matrix is in place so that staff's training can be easily monitored. This trainin matrix is available to staff.
12	5.3.3(d)	It is recommended that the ward manager ensures that all nursing staff receive supervision in accordance to Trust and professional standards and guidelines.	1	Immediate and ongoing	All staff receive supervision as per Trust guidance and professional standards and guidelines. A rolling programme of supervision is now in place within the ward. Sueprvision dates are reflected in the training matrix for Ward L.

NAME OF WARD MANAGER COMPLETING QIP	Jonathan Killough
NAME OF CHIEF EXECUTIVE / IDENTIFIED RESPONSIBLE PERSON	Martin Dillon, Acting Chief

APPROVING QIP	Executive

Inspector assessment of returned QIP				**Inspector**	**Date**
		Yes	**No**		
A.	Quality Improvement Plan response assessed by inspector as acceptable	x		Alan Guthrie	**8 December 2014**
B.	Further information requested from provider		x		

Ward Self-Assessment

Statement 1: Capacity & Consent • **Patients' capacity to consent to care and treatment is monitored and re-evaluated regularly throughout admission to hospital.** • **Patients are allowed adequate time and resources to optimise their understanding of the implications of their care and treatment.** • **Where a patient has been assessed as not having the capacity to make a decision there are robust arrangements in place in relation to decision making processes that are managed in accordance with DHSSPS guidance.** • **Patients' Article 8 rights to respect for private and family life & Article 14 right to be free from discrimination have been considered**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
A patient's capacity to consent will be considered on admission to the ward. Patients will be deemed to have capacity unless concerns regarding this arise. A capacity assessment will then take place and if necessary a Vulnerable Adult referral completed. Where a patient is deemed not to have capacity, decisions will be taken by the multidisciplinary team (in conjunction with the patient and their relatives/carers – the patient's representative/advocate can also attend where it is requested). Anyone deemed not to have capacity will have this reviewed regularly by a Consultant Psychiatrist. Patients and their relatives/carers are given an admission booklet on admission. This contains information including what to expect whilst on the ward and the complaints process. This booklet will be discussed with the patient and their relatives/carers by a member of staff or if preferred by the patient's advocate. Information on the patient's rights if detained will also be given to the patient both in written and verbal formats. Patients and their relatives/carers are fully involved in the development and review of their person centred care plan and risk management plan. Patients and their relatives/carers are also invited to the weekly multidisciplinary team meetings where their care plan and risk management plans are reviewed. In the event the patient and/or their relatives/carers do not wish to attend, staff will spend time obtaining their reviews so they can be considered by the multidisciplinary team. Time will also be spent following the multidisciplinary team meeting feeding back to the patient and/or their relatives/carers. A clear record of this will be made	Moving towards compliance

within the patient's notes. Patients are all asked to sign their care plans to show that they agree with the proposed way forward. If they do not wish to sign a clear record is made of the reasons for this. Patients are afforded 1:1 time with a member of nursing staff each day and are seen by their Consultant Psychiatrist weekly. Advocacy Services are in place for both patients and their relatives/carers should they wish to avail of this. Human rights including Article 8 and 14 are considered during the development of the patient's person centred care plan. There are now 8 single rooms within Ward L, Mater Hospital to afford more patients more privacy and dignity. All patients will be given a single room once the Acute Inpatient Unit at the Belfast City Hospital is open (it is expected this will happen in 2017). All patients have their own safe and access to the cash office at the Royal site. There are a number of child friendly rooms within Mater Psychiatric Hospital to facilitate visits from relatives/ carers. Whilst there are set visiting times, allowances will be made should a relative/carer need to visit outside of these hours. Patients can also meet up with their family when on pass. Pass allowances are reviewed on a weekly basis in the multidisciplinary team meeting.	
Inspection Findings: FOR RQIA INSPECTORS USE Only	
The inspector assessed the ward's policies and practices in relation to monitoring and evaluating of patients' capacity to consent to their care and treatment. The inspector reviewed four sets of patient care documentation and noted that care records evidenced that an admission check list, a joint mental state assessment, a medical examination, a nursing care plan, a physical assessment, an occupational therapy assessment and progress notes had been completed for each patient. Assessment of a patient's mental state was completed during the initial assessment process. If the outcome of the patient's mental state examination concluded that the patient was suffering from cognitive difficulties the patient's consultant psychiatrist then completed a capacity assessment using the mini mental state (MMSE) examination tool. In circumstances where a patient had been assessed as lacking the capacity to consent the patient's circumstances were monitored daily by nursing staff and reviewed weekly by the multi-disciplinary team (MDT). Care records reviewed by the inspector evidenced that nursing staff continually monitored each patient's progress and recorded any concerns or changes regarding the patient's presenting behaviour. Continued monitoring of each patient's circumstances was also facilitated through daily one to one time with	Not compliant

their named/associate nurse; through patient involvement in occupational therapy and ward group activity sessions; and by weekly review assessments with the consultant psychiatrist and the MDT.

The inspector reviewed the ward's protocols and procedures for the management of a patient assessed as not having capacity with three members of the nursing staff team. Staff explained the procedure they would follow when working with a patient in this situation. The actions described by staff were in accordance to DHSSPSNI guidance and demonstrated an appropriate and caring approach. This included undertaking continuous assessment of the patient's ability to consent and ensuring that decisions about the patient's care and treatment were agreed by the MDT, discussed with relatives/carers and reviewed on a regular basis. Care documentation reviewed by the inspector evidenced that patient nursing notes were comprehensive and provided detailed records of patient presentation including ongoing assessment of patient need and perceptions.

Each of the six ward staff who met with the inspector reflected that they felt the ethos and purpose of ward L had changed during the previous twelve months. As well as providing care and treatment to patients over the age of 65 the ward also provided treatment and care, at short notice, to patients who had been admitted to hospital on an emergency basis and in accordance to the Mental Health (Northern Ireland) Order 1986. The ward's ability to facilitate admissions of both male and female patients and the availability of eight single rooms gave it the flexibility to receive patients admitted at short notice. However, the inspector noted that on one occasion during the inspection and on two occasions during the five days prior to the inspection three patients had been moved, at short notice, to other wards to facilitate the emergency admission of patients who had been compulsory admitted under the Mental Health (Northern Ireland) Order1986.

The inspector met with each of the three patients who had been moved from ward L. The patients informed the inspector that although they had consented to move to another ward they had not wanted to leave ward L. The patients reported that they had moved at the request of nursing staff and they had been given limited notice that they were moving. The inspector was concerned that the unpredictability of patient admissions to ward L was negatively impacting on the treatment and care of patients who had already been admitted to ward L and were subsequently moved to facilitate new patient admissions. Furthermore, the inspector noted that one of the patients who had been moved was over eighty years old. This patient had been moved to a ward that provided care and treatment to a much younger female population. Given that the role of ward L is to provide care and treatment to patients over 65 the inspector found there was a lack of clarity regarding the ward's purpose, the patient profile and the criteria for and management of internal transfers between ward's J, K and L. A recommendation has been made.

All of the patients and staff who met with the inspector highlighted that the emergency admissions of new

patients and the subsequent relocating of current patients was causing continued disruption and concern. Given these circumstances the inspector concluded that the three patients who had been moved from ward L at short notice were not given adequate time and resources to optimise their understanding of the implications of their care and treatment. A recommendation has been made. Information provided to patients explained their article eight right to respect for private and family life and article 14 rights to be free from discrimination. This information was provided on the ward's notice board, in the patient information booklet and via the ward's advocate who was available on a monthly basis and could be contacted as required. Consideration of patient's article eight and article 14 rights was evidenced through the ward's visiting policy, by entries in patient care records regarding patient and staff contact with relatives and in patient care plans. Care plans reviewed by the inspector demonstrated that staff had considered each patient's privacy, dignity and family needs.	

Ward Self-Assessment

Statement 2: Individualised assessment and management of need and risk • **Patients and/or their representatives are involved in holistic needs assessment and in development of related individualised, person-centred care plans and risk management plans** • **Patients with communication needs have their communication needs assessed and there are appropriate arrangements in place to promote the patient's ability to meaningfully engage in the assessment of their needs, planning and agreeing care and treatment plans and in the review of their needs and services.** • **Assessment of need is a continuous process and plans are revised regularly with the involvement of the patient and/or their representative and in accordance with any changes to assessed needs.** • **Patients' Article 8 rights to respect for private and family life have been considered.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
Patients and their families/carers are fully involved in the development and review of their person centred care plan and risk management plan – these address physical, psychological and therapeutic needs of the patient. Patients and their relatives/carers are invited to the weekly multidisciplinary team meetings. As stated in Statement 1 in the event they do not wish to attend, time will be facilitated to obtain their views and feedback following the meeting. Human rights including Article 8 are considered when developing the patient's person centred care plan and risk management plan. Staff adhere to the Code of Practice 1992 pertaining to the Mental Health (NI) Order 1986. Any patient's communication issues will be addressed during initial assessment. The Belfast Trust has an established process in place to access interpreters. Staff will access an interpreter who can address the communication issue a person presents with. This is to enable the patient and their relatives/carers to continue to input into their care plan and risk management plan. There are also several bi-lingual members of staff on the ward team. There are now 8 single rooms within Ward L, Mater Hospital to afford more patients more privacy and dignity. All patients will be given a single room once the Acute Inpatient Unit at the Belfast City Hospital is open (it is	Moving towards compliance

expected this will happen in 2017). All patients have their own safe and access to the cash office at the Royal site. There are a number of child friendly rooms within Mater Psychiatric Hospital to facilitate visits from relatives/ carers. Whilst there are set visiting times, allowances will be made should a relative/carer need to visit outside of these hours. Patients can also meet up with their family when on pass. Pass allowances are reviewed on a weekly basis in the multidisciplinary team meeting. Staff attend Equality Training as per statutory/mandatory training. This training provides an overview of the key legislative and policy requirements relating to both Employment Equality and Section 75, Good Relations and Human Rights. This ensures that staff are made aware of the key concepts of equality and diversity, are provided with an overview of the main legislation and its practical implications and are familiarise with the Trust's Equality policies and their responsibilities there under.	
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
A patient assessment and care plan was available in each of the patient files reviewed by the inspector. Care documentation also included admission checklist and patient induction checklists. Patient risk assessments were comprehensive and care plans identified and addressed the patient's physical, psychological and therapeutic treatment and care needs. An occupational therapy assessment had also been completed with each patient. Each of the five patients who met with the inspector reported no concerns regarding the nursing, medical and occupational therapy support they received. Patients informed the inspector that they felt nursing staff were helpful and approachable and that they (patients) could meet with their consultant in private on a weekly basis. Patients also reported that staff had spoken to them about their care plan and staff kept them informed regarding their care and treatment arrangements. Patients' communication needs were addressed during the patient's initial assessment. The inspector reviewed the Trusts arrangements to support patients requiring communication assistance and noted that the Trusts interpreter service was available twenty four hours a day. Staff who met with the inspector demonstrated awareness and understanding of the Trust's interpreting service. The inspector was informed that should a patient require support from a speech and language therapist a referral would be made to the Trust's speech and language service. One of the files reviewed by the inspector evidenced that the patient's induction and admission checklists had not been completed. A second patient file contained an incomplete induction checklist and the patient had not signed their care plan. Recommendations regarding patient induction and admission checklists and the	Moving towards compliance

availability of patient signatures have been made. Patient care records were retained in a paper file and on the Trust's PARIS patient information system. The PARIS system contained updated nursing care assessments and patient progress notes. Continuous patient monitoring and review was also supported by the ward's smart board which all staff could access in the ward's main office. Ward L was supported by four consultant psychiatrists. Patients were allocated to a consultant in accordance to their care needs, gender and age. Ward L's ethos and objectives stated that the ward was designed to provide care and treatment for 14 patients over the age of 65 who had been diagnosed with a functional mental health problem (for example depression, schizophrenia). On the day of the inspection there were four patients who were 65 or older. The remaining ten patients were all under the age of 65 (patient ages ranged from 23-51) and each of the patients under 65 was under the care of one of the three remaining consultants who work within the facility. The inspector was informed that the ethos of ward L had changed and the ward was now providing care and treatment to a large number of newly admitted patients who were receiving treatment in accordance to the Mental Health (Northern Ireland) Order 1986. A recommendation has already been made. Patient progress within ward L was monitored by nursing staff on a daily basis and reviewed by the multidisciplinary team on a weekly basis. Patients and staff reflected that the communication and relationships between patients, nursing staff and the multi-disciplinary team (MDT) were supportive and positive. Patients and their relatives/carers were invited to attend their weekly MDT meetings. The ward held four MDT meetings, one for each of the consultants, each week. During the meetings each patient's progress including their care plan and risk assessment were reviewed. Consideration of each patient's Article 8 right to respect for private and family life was evidenced through the information provided to patients upon their admission. The inspector found evidence of patient involvement in their weekly care planning review, 1:1 time with staff and continued review meetings with their consultant. Patients who met with the inspector reported that they felt supported and staff had considered and listened to their views.	

Ward Self-Assessment	
Statement 3: Therapeutic & recreational activity • **Patients have the opportunity to be involved in agreeing to and participating in therapeutic and recreational activity programmes relevant to their identified needs. This includes access to off the ward activities.** • **Patients' Article 8 rights to respect for private and family life have been considered.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
There is a general activity programme displayed within Ward L. The programme for the Oasis café is also displayed on the ward. Therapeutic interventions and activities are considered as part of the patient's overall care plan which addresses a patient's physical, psychological and therapeutic needs. As stated the patient and their relatives/carers have input into their person centred care plan. Human rights including Article 8 are considered in developing the care plan. Each patient has their own individual activity programme which they have contributed to. Activities are facilitated both on and off the ward. Ward L has a dedicated OT who meets with patients regularly and attends the weekly multidisciplinary team meeting. The OT documents all therapeutic input on the Trust Community Information System. There are now 8 single rooms within Ward L, Mater Hospital to afford more patients more privacy and dignity. All patients will be given a single room once the Acute Inpatient Unit at the Belfast City Hospital is open (it is expected this will happen in 2017). All patients have their own safe and access to the cash office at the Royal. There are a number of child friendly rooms within Mater Psychiatric Hospital to facilitate visits from relatives/ carers. Whilst there are set visiting times, allowances will be made should a relative/carer need to visit outside of these hours. Patients can also meet up with their family when on pass. Pass allowances are reviewed on a weekly basis in the multidisciplinary team meeting.	Moving towards compliance

Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
The ward's patient information booklet relayed that there were a number of activities available to patients in ward L and these were provided by the ward's occupational therapist (OT) and nursing staff. During the inspection it was noted that ward L's OT had recently moved post. The inspector was informed that an OT had been appointed and would be taking up their post in September 2014. During the temporary absence of ward L's OT patients in ward L had been receiving OT support from the facilities two other OT staff who also provided services to ward's J and K. The facilities OT department was situated in ward J and utilised a large room which was used to provide ward based activities including: an anxiety management group, a recovery group and an alcohol and drugs information group. Activities were also provided in the facilities gym and the Oasis room. Patients from ward L could participate in a weekly pilates class, the green gym or the bunch group which was held on Tuesday mornings in the Oasis room. The inspector visited the gym, the Oasis room and the OT room and noted the rooms to be spacious, bright, well maintained and appropriately equipped. A weekly OT activity sheet was posted on the notice board in ward L's main reception. The activities sheet indicated that from the 4 August 2014 to 8 August 2014 patients in ward L could attend the brunch group in the Oasis room on Tuesday morning and the green gym on Wednesday. The green gym included gardening activities facilitated in the ward's outside areas and in other locations outside the hospital. A pilates class was also available on Friday morning although this had been assessed as not currently suitable for patients in ward L due to patient health concerns. Upon admission to ward L each patient was offered an OT assessment to help identify which activities would be appropriate and to provide an individualised activity programme. Patient participation in activities was reflected in the care documentation reviewed by the inspector. Ward staff who met with the inspector reflected positively on the role of the OT service and the engagement and support offered to patients by the OT staff team. Patient participation in activities was discussed and reviewed on a weekly basis by the multi-disciplinary team. On the day of the inspection the inspector was informed that ward L did not currently have support from the Trust's psychology services. In a previous patient experience inspection completed on the 6 June 2014 the inspector was advised that a new psychologist had been appointed and would be taking up post 'in the next few weeks' and a further psychologist would be returning from long term leave on the 7 July 2014. Subsequently, given that patients in ward L could not access ward based psychology support the recommendation made as a result of the inspection in June 2014 will be restated for a second time. The inspector discussed the provision of psychology services with the services manager. The services manager reported that a psychologist was due to commence post on the 7 September 2014.	Substantially compliant

The inspector was able to evidence that patient's article eight rights to respect for private and family life had been considered with regard to the provision of therapeutic and recreational activities. This was evidenced through the provision of a range of individual and group activities which patients could choose to attend. Patients on ward L could also access a gym and a patient's cafeteria/recreation room (Oasis room) and activities outside the hospital were also available. Visiting times with family or friends were protected and flexible and not negatively impacted on as a result of the therapeutic and activity programmes. Visits from patient's children/grandchildren could also be facilitated in separate visiting rooms located outside ward L. Trust guidance regarding visits from children was available, appropriate and up to date.	

Ward Self-Assessment

Statement 4: Information about rights • **Patients have been informed about their rights in a format suitable to their individual needs and access to the communication method of his/her choice. This includes the right to refuse care and treatment, information in relation to detention processes, information about the Mental Health Review Tribunal, referral to the Mental Health Review Tribunal, making a complaint, and access to independent advocacy services.** • **Patients' Article 5 rights to liberty and security of person, Article 8 rights to respect for private and family life and Article 14 right to be free from discrimination have been considered.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
As stated in previous statements all patients and their relatives/carers are given a welcome booklet on admission. This includes information on the detention process, information on the role of the Mental Health Review Tribunal, Making a Complaint and access to advocacy services. This will be discussed with a member of nursing staff or an advocate if the patient prefers. If needs be an interpreter will be requested. The ward's advocate will introduce themselves to any new patients on the ward during their visits and discuss any issues they have. The ward's advocate will also speak to other patients on the ward to establish any concerns or queries they may have. The advocate will then discuss these with ward staff in order to find a way forward. The assessment process and development of care plans and risk management plans will consider the patient's human rights including Articles 5, 8 and 14. Patients will have access to the same services i.e. podiatry, dentist, GP etc whilst in hospital as they would if living in the community. Some patients admitted to Ward L will be involved in day care services. Staff will facilitate their continued attendance to day care services so they can maintain this contact. There are now 8 single rooms within Ward L, Mater Hospital to afford more patients more privacy and dignity. All patients will be given a single room once the Acute Inpatient Unit at the Belfast City Hospital is open (it is expected this will happen in 2017). All patients have their own safe and access to the cash office at the Royal site.	Moving towards compliance

There are a number of child friendly rooms within Mater Psychiatric Hospital to facilitate visits from relatives/ carers. Whilst there are set visiting times, allowances will be made should a relative/carer need to visit outside of these hours. Patients can also meet up with their family when on pass. Pass allowances are reviewed on a weekly basis in the multidisciplinary team meeting.	
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
Ward L provided patients with a range of information leaflets which explained and promoted the rights of patients. The ward's admission checklist included an entry to ensure that patients had been provided with information about their rights. Upon admission patients were also given a patient's information booklet. Section nine of the booklet provided advice in relation to patient's rights including a patient's right to be treated fairly and with dignity and respect. Patients admitted to hospital in accordance with the Mental Health (Northern Ireland) Order 1986 were also provided with information regarding their rights under the Mental Health (Northern Ireland) Order 1986. This included the right of a patient to challenge their compulsory admission to hospital through independent review by the Mental Health Review Tribunal. The patient's booklet and the Mental Health (Northern Ireland) Order 1986 information included the contact addresses and telephone numbers of independent voluntary and statutory support services for patients and their carers/relatives. Ward L's main notice board and reception area displayed a range of information about the ward's routine, the advocacy service and the complaints process. The inspector noted the availability of information regarding the patient's rights and consent to care and treatment and the 'see something say something' information leaflet regarding the protection of vulnerable people. Patients could also attend the 'have your say' meetings which were held on the ward every two weeks. These meetings were facilitated by ward staff and gave patients the opportunity to discuss any concerns/compliments or recommendations they might have regarding ward L. The patient information booklet explained that advocacy support was available upon request and the advocate could represent patients at their care and treatment review and provide support with any problems or complaints the patient may have. Contact information regarding ward L's independent advocacy service was available on two of the ward's notice boards. The inspector reviewed the advocate records and noted that the advocate had visited the ward on three occasions during the previous eight months. The inspector was informed that the advocate called to the ward as and when required. Information provided to patients admitted to ward L demonstrated that consideration had been given to patient's article 5 right to liberty and security of person, article 8 right to respect of private and family life and article 14 right to be free from discrimination. Consideration of patient's rights was also evidenced in patient care documentation, through the patient 'have your say meetings', through the ward's independent complaints process and by the availability, upon request, of an independent patient advocate.	Compliant

Ward Self-Assessment

Statement 5: Restriction and Deprivation of Liberty • **Patients do not experience "blanket" restrictions or deprivation of liberty.** • **Any use of restrictive practice is individually assessed with a clearly recorded rationale for the use of and level of restriction.** • **Any restrictive practice is used as a last resort, proportionate to the level of assessed risk and is the least restrictive measure required to keep patients and/or others safe.** • **Any use of restrictive practice and the need for and appropriateness of the restriction is regularly reviewed.** • **Patients' Article 3 rights to be free from torture, inhuman or degrading treatment or punishment, Article 5 rights to liberty and security of person, Article 8 rights to respect for private & family life and Article 14 right to be free from discrimination have been considered.**	**COMPLIANCE LEVEL**
Ward L operates an open door policy. Patients are asked to remain on the ward for 24 – 48 hours however this is to facilitate a comprehensive assessment of their mental state and the reason is fully explained to the patient and their relatives/carers. The reason for this is also explained in the ward's welcome booklet which is shared with the patient and their relatives/carers. There are now 8 single rooms within Ward L, Mater Hospital to afford more patients more privacy and dignity. All patients will be given a single room once the Acute Inpatient Unit at the Belfast City Hospital is open (it is expected this will happen in 2017). All patients have their own safe in which to store belongs. Apart from the request to remain on the ward for 24 – 48 hours during initial admission there are no other blanket restrictions imposed on patients. Any restriction posed on a patient will be following a thorough mental state and risk assessment. This will be considered on a case to case basis. The rationale for any restriction will be fully explained to the patient and their relatives/carers. Any restriction placed on a patient will be reviewed regularly in keeping with Trust and Regional Guidance to ensure the least restrictive practice is imposed on patients. Any restrictive practice will be used as a last resort and be proportionate to the level of risk posed as outlined in the patient's care plan and risk management plan (the patient's human rights including Article 5, 8 and 14 will be considered when developing same). Any restriction will be reviewed at the weekly multidisciplinary team	Moving towards compliance

review (or sooner if necessary) at which the patient and relatives/carers are invited to attend. Staff work to Trust and local policies and procedures and regional guidance. All staff on the ward are trained in MAPA skills. A record of all restraints are made. Restraints are reviewed during the weekly multidisciplinary team meeting and audited by the Resource Nurse for Mental Health and Learning Disability. The results of this are shared with management and will highlight any issues around practice etc. There are now 8 single rooms within Ward L, Mater Hospital to afford more patients more privacy and dignity. All patients will be given a single room once the Acute Inpatient Unit at the Belfast City Hospital is open (it is expected this will happen in 2017). All patients have their own safe and access to the cash office at the Royal site. There are a number of child friendly rooms within Mater Psychiatric Hospital to facilitate visits from relatives/ carers. Whilst there are set visiting times, allowances will be made should a relative/carer need to visit outside of these hours. Patients can also meet up with their family when on pass. Pass allowances are reviewed on a weekly basis in the multidisciplinary team meeting.	
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
The patient's booklet provided patients with information regarding the ward environment, observation levels, smoking and the prohibited use of alcohol and drugs. The booklet explained that upon admission patients were asked to remain on the ward for the first 24-48 hours to facilitate the completion of a comprehensive assessment. Patients could leave the ward as required via the main entrance door which was locked from the outside but could be opened from inside the ward. Restrictions regarding smoking and the use of alcohol and drugs were clearly stated in the information booklet and patients on ward L could access a designated smoking area within the ward's outdoor space which was located in the middle of the ward. The inspector reviewed four sets of patient care documentation and noted that when restrictive practices were used with patients the need for the restriction had been individually assessed and a rationale was available explaining why the restriction had been put in place. The inspector noted that one patient had their razors removed and these were retained by staff in the ward's main office. The inspector reviewed the patients care documentation and found evidence that the patient had been assessed as presenting as a risk to themselves and staff were concerned that the patient's razors could present as a self-harm risk to the patient. A rationale for the removal of razors had been recorded on the patient's care documentation and this had been agreed by the multi-disciplinary team. The patient's risk assessment and care plan recorded the use of the restriction. The patient could access their razors as required and upon request to a member of nursing staff. The inspector	Substantially Compliant

was informed that the use of any restrictive practice with a patient was monitored on a daily basis and would desist when the patient was assessed as being no longer at risk. The inspector reviewed the ward's physical intervention and observation policies and procedures. The inspector noted the policies and procedures to be appropriate and in accordance with Trust and regional guidance. The inspector met with one patient who had experienced enhanced observations. The patient reported that staff had been supportive and respectful and the reasons why observation was being used had been explained to them. The use of observation with the patient had been agreed by the consultant psychiatrist, reviewed on a daily basis by the nurse in charge and on a weekly basis by the multi-disciplinary team. The use of observation was also monitored by the facilities nursing services manager. The use of restraint with patients was recorded on a restraint record which was available on the Trust's Paris information system. The use of restraint was also recorded as an incident, reviewed by the multi-disciplinary team and audited by the mental health resource nurse and the Trust's governance department. Incident records reviewed by the inspector detailed one incident requiring the use of restraint during the month of July 2014. The incident involved a member of staff removing a patient's hands from the staff member's throat. The patient had been unwell and the staff member was able to deescalate the situation and remove the patient's hands from their neck. The incident had been recorded in accordance to Trust guidance and was subsequently assessed as not significant in severity and requiring no further investigation. The ward's training records detailed that five members of the ward's 22 nursing staff required managing actual and potential aggression (MAPA) update training. The inspector was informed that training for the five staff would be completed in the near future via the Trust's essential skills training week. A recommendation regarding the completion of mandatory training has been made. The inspector noted that patients' article three right to be free from torture, article eight right to a private and family life and article 14 right to be free from discrimination had been considered. This was evidenced through entries in patient care documentation and through ward staff(s) use of restrictive practices. Records reviewed by the inspector demonstrated that restrictive practices were individually assessed, proportionate, continually monitored by nursing staff, the multi-disciplinary team and the Trust and completed in accordance to Trust policy and procedure.	

Ward Self-Assessment

Statement 6: Discharge planning • **Patients and/or their representatives are involved in discharge planning at the earliest opportunity.** • **Patients are discharged home with appropriate support or to an appropriate community setting within seven days of the patient being assessed as medically fit for discharge.** • **Delayed discharges are reported to the Health and Social Care Board.** • **Patients' Article 8 rights to respect for private and family life have been considered.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
Patients and their relatives/carers are invited to contribute to all aspects of their treatment and care. Work towards discharge commences when the patient is deemed fit for discharge. Discharge planning will involve the patient and their relatives/carers. A discharge meeting will take place. The patient and their relatives/carers, those involved with the patient prior to admission and will be involved with the patient following discharge and the multidisciplinary team meeting will be invited to attend. Discharge plans are person centred and take into consideration the patient's human rights including Article 8. All patients discharged from Ward L will receive a seven day follow up appointment. Any delayed discharges are reported to the Health and Social Care Board. A meeting will also be set up to discuss these. The purpose of which is to ascertain the reasons for the delayed discharge and to work on a package to enable the patient's discharge.	Moving towards compliance
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
Discharge planning was discussed with patients and their relatives/carers upon their admission and this was evidenced in patient care documentation reviewed by the inspector and within the patient's discharge plan. The patient information booklet included sections describing the arrangements for patient discharge and the importance of home leave to assist the patient in working towards returning home as soon as possible. Discharge planning for each patient was reviewed and discussed at the patient's weekly multi-disciplinary care review meeting. The patient and their relative/carer were invited to attend the meeting. The patient's	Compliant

consultant, the ward manager/charge nurse, the patient's named nurse, the ward's social worker, the ward's occupational therapist and a member of the crisis response and home treatment team were also invited to attend. Discharge planning ensures that arrangements for the continuation of outpatient treatment and provision of any services or social support including housing are discussed. Upon the patient's discharge a referral to the patients local community mental health team (CMHT) is completed and a follow up appointment, within seven days of the patient's discharge, is arranged. The patient's is then transferred to the CMHT worker identified as the patient's keyworker. The role of the keyworker is to provide community based treatment and support to the patient. The inspector noted that the patient's article 8 rights to respect for private and family life had been considered. This was evidenced through the patient's right to attend their weekly care plan review which included discussions regarding the patients discharge plan. Patients and staff who met with the inspector reflected that the involvement of relatives/carer in the care and treatment of the patient was promoted and enabled throughout the patient's admission. The ward operated flexible visiting hours and during the inspection the inspector noted relationships between staff, patients and visitors to be appropriate and respectful. The inspector was informed that one patient's discharge had been delayed and this has been recorded in accordance to the Health and Social Care Board. The patient was awaiting the provision of appropriate accommodation to ensure that their care needs were fully met.	

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

Inspector's overall assessment of the ward's compliance level against the statements assessed	COMPLIANCE LEVEL
	Inspector to complete