RQIA

Mental Health and Learning Disability

Unannounced Inspection

Cranfield Female

Muckamore Abbey Hospital

Belfast Health & Social Care Trust

2 & 3 February 2015

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1.0 General Information

Ward Name	Cranfield Female
Trust	Belfast Health & Social Care Trust
Hospital Address	Muckamore Abbey Hospital 1 Abbey Road Muckamore BT41 4SH
Ward Telephone number	028 94 662299
Ward Manager	Adrienne Creane
Email address	Adrienne.creane@belfasttrust.hscni.net
Person in charge on day of inspection	Adrienne Creane
Category of Care	Mental Health
Date of last inspection and inspection type	11 June 2014, Patient Experience Interviews
Name of inspector Name of Lay assessor	Wendy McGregor Alex Parkinson

2.0 Ward profile

Cranfield Women's is a fifteen bedded female admission ward on the Muckamore Abbey Hospital site. The purpose of the ward is to provide assessment and treatment to female patients with a learning disability who need to be supported in an acute psychiatric care environment.

The ward is connected to Cranfield Men's ward which is the male acute admission ward and Cranfield ICU, which is the intensive care unit. All three wards can be gained via a corridor linking all three Cranfield wards.

Patients within Cranfield Women's have access to a multi-disciplinary team which incorporates psychiatry, nursing, psychology, occupational therapy, behavioural support, speech and language therapy, and social work professionals. Patient advocacy services were also available.

The ward had an open planned structure which created space for patients who had mobility issues to move freely and safely around the ward. Patients had their own bedroom with en-suite facilities. Bedrooms were noted to be personalised. Patients had access to a garden.

Several visitor rooms were available. Signage to the ward was clear and there were written and pictorial/photographic signs on the internal doors which supported patients with orientation.

On the days of the inspection were thirteen patients on the ward and two patients on leave. Of these there were eight patients detained 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 unannounced inspection of Cranfield Female was undertaken on 2 and 3 February 2015.

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

The recommendations made following the last announced inspection on 9 July 2013 were evaluated. The inspector was pleased to note that 20 recommendations had been fully met.

However, despite assurances for the Trust, one recommendation had been partially met and one recommendation had not been met.
Two 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

There were no recommendations made following the patient experience interview inspection on 11 June 2014.

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

The recommendations made following the finance inspection on 31 December 2014 were evaluated. The inspector was pleased to note the recommendations had been fully met.

Details of the above findings are included in Appendix 1.

5.0 Inspection Summary

Since the last inspection it was good to note that progress had been made in meeting recommendations made following the previous announced inspection. There was evidence of patient and relative involvement in decisions in relation to their care and treatment plans. It was noted that improvements have been made in relation to safeguarding vulnerable adults as policies and procedures in safeguarding vulnerable adults was included in the induction programme for new staff, protection plans were in place and there was a formalised mechanism to alert the safeguarding officer to multiple referrals. It was good to note that all staff had received up to date training in safeguarding vulnerable adults and physical interventions. The inspector was informed by behaviour support staff that there are plans to increase the number of behaviour support staff in the hospital.

The inspector observed staff providing care and support to patients with a range of different needs, abilities, levels of understanding and communication

needs. Patients on the ward also presented with a number of behaviours that challenge. Staff were observed treating patients with dignity and respect.

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.

Information in relation to Department of Health Guidance on Capacity and Consent was available for staff. Patients or where appropriate their relatives were involved in decisions in relation to capacity to consent. Patients had been given time to understand their care and treatment plans. Staff sought consent prior to care delivery. Staff demonstrated their knowledge of capacity and consent and when to use the best interest check list and decision making tool. Information on patients' capacity to manage and control their finances was included in the two sets of care documentation reviewed. Where appropriate, financial control forms had been completed and signed by the consultant psychiatrist.

Patients had holistic needs assessments and individualised, person centred care plans completed with patient and, where appropriate, relative involvement. Care plans addressed each identified assessed need. Promoting Quality Care risk screening tool and subsequent comprehensive risk assessments had been completed where required. However, patient and or relative involvement was inconsistent. A relevant recommendation has been made. Care plans were reviewed at the weekly multi-disciplinary meetings and changes made when necessary. Patients and / or their relatives were offered the opportunity to attend their weekly multi-disciplinary meetings. Care plans and risk management plans reviewed in relation to responding to patients who present with behaviours that challenge detailed proactive strategies as well as reactive strategies.

Patients had a communication assessment completed and were referred to speech and language therapy services were assessed as needing support with communication. Patients were provided with alternative means to support them with communication. Staff were observed to engage with patients using therapeutic communication. Staff had knowledge of how to best support patients with their communication needs.

Patients had therapeutic and recreational activity assessments completed with individual activity plans with patient and relative involvement. Patients had access to Moyola day care facility. Ward based activities that were available were on display in the patient communal area. Patient participation in activities was monitored and recorded daily. During the inspection some patients were participating in activities, however the inspector noted that activity based proactive strategies as detailed in one patients care documentation were not being implemented. A recommendation has been made.

Patients and the advocate stated that there wasn't enough ward based activities provided. This was also raised at patient forum meetings. Staff

indicated that it was difficult to provide activities when the ward was busy. A recommendation has been made.

The inspector and lay assessor observed that information on who was on duty, ward based activities, independent advocacy services and how to make a complaint was displayed in the patient communal areas. A ward information booklet was available in an easy to read format. Patients could raise areas of concern at patient forum meetings convened every two months. Patients who were detained in accordance with the mental health (Northern Ireland) Order 1986 had been informed of their rights to appeal to the Mental Health Review Tribunal.

Patients had been informed of their rights in relation to their detention, how to make a complaint, and how to access advocacy services. Staff were aware how to effectively utilise advocacy services and automatically referred patients to independent advocacy services on admission. Independent advocates were invited to attend patients' progress meetings. Relatives had been informed of advocacy services.

Patients had individualised restrictive practice and deprivation liberty care plans completed with patients and relative involvement. Each restriction had a clear rationale recorded that was proportionate to the risk. Restrictive practices were reviewed regularly and changes made where appropriate. The inspector reviewed documentation in relation to the use physical interventions for one patient and staff had not completed a body map and not accurately completed the physical intervention form. This has been addressed separately with the trust and assurances given that any gaps identified will be addressed through an action plan. Physical intervention forms are audited by the physical intervention team.

Incidents resulting in the use of restrictive practices are reviewed by senior management at the monthly core meetings and at the monthly unit meetings. Patients and relatives had been informed of restrictive practices on the ward. Staff demonstrated their knowledge and understanding of the Deprivation of Liberty Safeguards – Interim Guidance DHSSPS 2010.

Staff had knowledge of patients Human Rights Article 3; the right to be free from torture, inhuman or degrading treatment or punishment, Article 5; the right to liberty and security of person Article 8; the right to respect to private and family life and Article 14; the right to be free from discrimination.

Consideration of patients Human Rights Article 3; the right to be free from torture, inhuman or degrading treatment or punishment, Article 5; the right to liberty and security of person Article 8; the right to respect to private and family life and Article 14; the right to be free from discrimination was recorded in the patients care documentation.

Details of the above findings are included in Appendix 2.

On this occasion Cranfield Women's ward has achieved an overall compliance level of substantially 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	**Four**
Ward Staff	**Two**
Relatives	**None**
Other Ward Professionals	**Five**
Advocates	**One**

Patients

The inspector was joined by a lay assessor on the inspection. Three patients met with the inspector and one patient met with the lay assessor.

The three patients that met with the inspector indicated they knew why they were in hospital. Patients also stated they had been involved in their care and treatment plans. Patients all commented that they had a good relationship with their named nurse and had the opportunity to spend time with them. Patients knew what an advocate was and had used this service. Patients stated they felt safe on the ward. Patients stated they got time off the ward and attended both day care and activities in the community. Although patients stated there wasn't enough activities happening as they "often felt bored". All patients stated they were overall satisfied with the quality of care and treatment.

One patient met with the lay assessor. The patient informed the lay assessor that;

- They felt safe
- They could talk to staff if they were unhappy
- They knew who their doctor was
- They knew who their named nurse was
- They were well cared for
- Being in hospital has helped them
- They did not receive an update all the time
- There took part in activities
- They felt like they were getting better
- Staff had time to talk to them about how they were being cared for
- They got time off the ward

- It was easy for them to see their friends and family
- They can use the phone on the ward
- Exit from the ward was locked but the door was opened if they needed to go out
- The garden is open
- They had a key for their bedroom door

Relatives/Carers

The inspection was unannounced. There were no relatives available during the inspection.

Ward Staff

Two ward staff met with the inspector. Staff demonstrated their knowledge and understanding of individual patients needs on the ward and demonstrated how they adjust their communication to support patients who require support with communication. Staff indicated that although caring for the patients was rewarding, working on the ward can be challenging at times due to the different range of patient needs, level of understanding and the number of patients who present with behaviours that challenge. However staff stated they felt well supported by the ward sister.

Other Ward Professionals

The inspector met with an occupational therapist, designated officer, physical interventions co-ordinator and behaviour support staff. Staff indicated that team work was good and staff make appropriate referrals.

Advocates

The inspector met with one independent advocate. The advocate stated overall the care on the ward was good. Staff made appropriate referrals. Concerns raised by patients were addressed. The advocate stated that patients who do not attend day care complained of “boredom”.

Lay assessor feedback

The lay assessor informed the ward sister of the outcomes from speaking with the patient. The inspector reviewed the patients documentation and noted the patient was involved with their care and treatment plans and had been kept up to date in relation to any proposed changes to their care plans.

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	6	2
Relatives/carers	14	6

Ward Staff

Seven questionnaires were returned from staff nurses and health care assistants. Six out of seven staff had not received training in capacity and consent. The ward sister informed the inspector that dates have been arranged for staff to attend this training and information in relation to capacity and consent is shared at team meetings. All staff stated they had received training in Human Rights and were aware Deprivation of Liberty Safeguard (DOLS) – Interim Guidance (2010). All staff were aware of the restrictive practices on the ward. All staff stated patients communication needs were recorded in their assessment and care plans and the ward had processes in place to meet patients' individual communication needs. All staff stated the ward has information in a format to meet individual needs in relation to patients' rights. All staff stated that patients had individualised activity programmes in plans and patients had access to therapeutic and recreational activities.

Other Ward Professionals

Two questionnaires were returned by the hospital aroma therapist and behaviour specialist. The aroma therapist visited the ward to provide treatment to patients when referred. The behaviour specialist had received training in capacity and consent and Human Rights and was aware of Deprivation of Liberty Safeguard (DOLS) – Interim Guidance (2010). The behaviour specialist had received training in relation to restrictive practices. The behaviour specialist had received training on meeting the needs of patients who require support with communication and confirmed that patients communication needs were recorded on their assessment and care plan. The behaviour specialist stated that patients on the ward had access to recreational and therapeutic activities.

Relatives/carers

Six questionnaires were returned by relatives. Relatives rated the care on the ward from good to excellent. Relatives indicated, where appropriate, they were involved in their family members care and treatment plans. Where relatives stated a formal assessment had been completed where there were concerns in relation to their family members ability to consent. Relatives stated their family member took part in recreational and therapeutic activities. Where appropriate relatives stated their family member had been informed of their rights in relation to their detention. All relatives stated they had been informed of advocacy services. Relatives stated they had been involved in a person centred discharge plan where appropriate.

Relatives quoted;

"The care and service provided on the ward to my relative is very good. The consultant, nursing, auxiliary / medical team staff and all other staff in the unit are helpful, friendly, approachable and keep me informed of all aspects of my relatives treatment."
"Pleased with the care my relative is receiving."

"We are quite happy with the care our relative receives in hospital."

7.0 Additional matters examined/additional concerns noted

Complaints

The ward was asked to complete a record of any complaints received between 1 April 2013 and 31 March 2014. The inspector confirmed that there have been no formal or informal complaints received on the ward.

Summary of Lay assessor observations.

The lay assessor completed a direct observation of the ward.

The lay assessor observed the following;

- Staff talked to the patients
- The ward was clean, tidy warm and had a nice smell
- The ward was not noisy
- Patients knew where to go on the ward
- Staff helped patients when they needed it
- Patients were not doing activities
- Staff were nice to patients
- Names of staff were on display; however this was not in a format that meet all the communication needs of the patients on the ward. A recommendation has been made
- Staff explained what they were doing with the patients before they started
- There was information displayed about advocacy services
- There was information about the ward for patients
- The lay assessor stated the ward was good.

The lay assessor informed the ward sister of their findings and the recommendation that will be made.

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

Appendix 1

Follow-up on recommendations made following the announced inspection on 9 July 2013

No.	Reference.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	17 section 5.3.3(a)	It is recommended that patients' involvement in the assessment and care planning process is consistently documented. (2)	The inspector reviewed care documentation in relation to two patients and spoke with three patients on the ward. There was evidence that patients were involved in their assessments and the care planning process.	Fully met
2	18 Section 3	It is recommended that the ward sister ensures that policies, procedures, guidance and training in safeguarding vulnerable adults is included and recorded in the induction programme for new staff.	The Inspector reviewed the wards induction procedures and noted that guidance on safeguarding vulnerable adults and child protection was included.	Fully met
3	18 Section 5	It is recommended that the trust ensures that details of protection plans developed in response to adult safeguarding referrals are documented clearly on the safeguarding documentation.	The inspector reviewed documentation in relation to safeguarding vulnerable adult referrals for one patient and noted that the details of protection plans were clearly included in the documentation. Timely review of the protection plan was also noted. The inspector met with the hospital safeguarding vulnerable adult officer designated officer (DO) who confirmed that protection plans are completed promptly when a referral is completed.	Fully met
4	18 Section	It is recommended that the trust	The inspector met with the hospital	Fully met

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	1	ensures that a formal mechanism to alert the safeguarding officers to multiple referrals due to the same alleged perpetrator is developed, implemented and included in the Trust Vulnerable Adult Safeguarding Procedures.	safeguarding vulnerable adult officer designated officer (DO). All referrals are forwarded to the DO and a formal mechanism is now in place to alert when there are multiple referrals due to the same perpetrator. This is included in the Trust Vulnerable Adult Safeguarding Procedures.	
5	12 Statements 3;8;11	It is recommended that the ward sister ensures that risk assessments and care plans are discussed with the patient and their carer. This should be evidenced within the care documentation.	The inspector reviewed risk assessments and care plans in relation to two patients. There was evidence that care plans had been discussed with both patients. However there was no evidence the risk assessment had been discussed with one patient or a rationale recorded why this had not occurred. This recommendation will be restated for a second time.	Partially met
6	12 Statements 3;8	It is recommended that the ward sister ensures that the template for recording the multi-disciplinary team meetings includes domains to record patient/relative views/involvement, names of those present, agreed actions and outcomes including responsibility for completion, agreed timescales for completion, and review of risks.	The inspector reviewed the template for recording multi-disciplinary team meetings. The template included patients/ relative views / involvement, the names of those present, agreed actions and outcomes including responsibility for completion, agreed timescales for completion and review of risks.	Fully met

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7	17 Section 5.3	It is recommended that the ward sister introduces a system of auditing of records and record keeping to ensure defined processes are followed by relevant staff.	The inspector noted a system for auditing records and record keeping had been introduced and ensured defined processes were followed by relevant staff. The last audit was completed on 27 January 2015. The audit tool used was in keeping with NMC standards for record keeping and NIPEC guidance for record keeping. The audit was also noted to consider recommendations made by RQIA inspections on other wards in Muckamore.	Fully met
8	6	It is recommended that the trust ensures that staff within Cranfield Women's receive awareness training on their role in relation to Deprivation of Liberty Safeguards (DOLS) – Interim Guidance, as outlined by the DHSSPSNI in October 2010.	The inspector reviewed the training records for staff working on the ward and noted that 15 out of 30 staff had received awareness training in relation to Deprivation of Liberty Safeguards (DOLS) – interim guidance as outlined by DHSSPSNI (2010). The inspector noted that the 15 staff who had attended were staff nurses. Dates have been arranged for the remaining staff to attend awareness training.	Fully met
9	6	It is recommended that the ward sister ensures that the Deprivation of Liberty Safeguards (DOLS) – Interim Guidance, as outlined by the DHSSPSNI in October 2010, is implemented within Cranfield Women's ward.	The inspector reviewed care documentation in relation to two patients and noted that individualised care plans in relation to DHSSPSNI Deprivation of Liberty Safeguards (DOLS) - interim guidance (2010) had been completed. All staff spoken to during the inspection	Fully met

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			demonstrated their knowledge of the DOLS guidance.	
10	6	It is recommended that the ward sister ensures that care plans in relation to actual or perceived deprivation of liberty are reviewed to ensure that an explanation of deprivation of liberty is included and relevant to the plan of care.	Since the last inspection, new care documentation has been introduced. The inspector reviewed care plans in relation to actual or perceived deprivation of liberty completed for two patients. The inspector noted that an explanation for the deprivation of liberty was recorded in the care plan	Fully met
11	6	It is recommended that the trust ensures that the 'restriction checklist' currently in use on the ward is reviewed to ensure that the implementation of this tool is appropriate to the care environment.	The "restriction check list" is no longer used on the ward. Patients who present with risks that require restrictions were individually assessed and recorded in patients care documentation. This was evidenced in the two sets of care documentation reviewed during the inspection.	Fully met
12	12 Standard 13	It is recommended that the ward sister ensures that a timetable of ward based activities is developed, implemented and shared with patients.	The inspector observed a list of ward based activities on offer was displayed in the ward communal area. Activities on offer for the days during the inspection were recorded on the ward staffing notice board. A timetable had not been completed as this would not meet the individual needs of the patients. However patients and the ward advocate stated there was not enough activities occurring. Patients stated they were often	Fully met

			bored when they did not attend day care. A new recommendation will made in relation to ward based activities.	
13	17 Section 4.3	It is recommended that the trust ensures that a needs/capacity analysis is undertaken to establish need for and availability of clinical therapeutic inputs to include psychiatric, psychological, behavioural, social work and occupational therapy specialties.	The trust had undertaken a needs/capacity analysis and the inspector noted patients on the ward had access to the following; One full time hospital occupational therapist One part time hospital based psychologist Three full time behaviour therapists with a plan this will increase by three in April 2015. Two full time hospital social workers One full time consultant psychiatrist One special registrar One ward doctor.	Fully Met
14	16	It is recommended that the trust ensures that a new policy for mobile phone use is developed and implemented.	The inspector was informed that a policy for mobile phone use was not developed and there are no plans to develop one in the future. Risks on mobile phone use will assessed on an individual basis and patients will retain their mobile phones unless risks were identified.	Fully met
15	17 Section 4.3	It is recommended that the trust ensures that the supervision needs for all staff working on the ward is examined and that a timetable of supervision for all staff working on the ward is developed and	The inspector noted a timetable for supervision for all staff working on the ward was displayed in the ward office and indicated when supervision had been completed and the date staff were due their supervision.	Fully met

		implemented so that staff receive regular supervision appropriate to their needs and role.		
16	18 Section 2	It is recommended that the trust put a system in place so that the ward sister/nurse in charge can ensure that bank staff have the appropriate training skills and knowledge to work on the ward.	The inspector was informed by the senior manager that all bank staff had received up to date mandatory training and have the appropriate training skills and knowledge to work on the ward.	Fully met
17	17 Section 4.3	It is recommended that the ward manager ensures that a training needs analysis is undertaken and that a training plan is developed from the findings of this analysis.	The ward sister informed the inspector that staff training needs are identified through staff appraisals and supervision. The inspector reviewed training records and noted that all staff had received up to date mandatory training. Dates for positive behaviour support training have been arranged and confirmed.	Fully met
18	20 Standard 8	It is recommended that to promote optimum levels of care and treatment, the trust put a mechanism in place to ensure that staff at all levels working with patient's on Cranfield Women's Ward are fully supported in their role.	The inspector reviewed records in relation to staff supervision and noted that all staff had received up to date supervision. The inspector noted that staff meetings had been convened two monthly. Staff interviewed during the inspection stated they felt fully supported in their role.	Fully met
19	12	It is recommended that the ward sister ensures that information	The inspector noted that information relating to staff on duty was displayed in the patient	Fully met

		relating to staff on duty is displayed in patient areas.	area. A new recommendation will be made following observation by the lay assessor.	
20	17 Section 8.1	It is recommended that the trust ensures that the local complaints resolution form is completed as necessary.	The inspector reviewed information to guide staff on how to support patients to make either a formal or informal complaint was held on the ward. Local resolution forms were available. Information on how to make a complaint was displayed in the patients' communal areas. Patients interviewed during the inspection knew who to speak to if they were unhappy. The ward sister stated there have been no formal or local complaints on the ward.	Fully met
21	17 Section 5.3	It is recommended that the trust ensures that all care documentation is accurate, current, personalised and in keeping with relevant published professional guidance documents including NMC Record keeping guidance and DHSSPSNI 2010 Deprivation of Liberty Safeguards (DOLS) – Interim Guidance.	The inspector reviewed care documentation in relation to three patients. It was noted that records completed following the use of a physical intervention with one patient had not been completed accurately and did not reflect the information written in the daily progress notes. This recommendation will be restated for a second time.	Not met
22	18 Section 5	It is recommended that the trust ensures that a system to provide the ward sister with information in	The inspector noted the minutes of monthly senior management core meetings were shared at the unit meetings attended by the	Fully met

		relation to review and outcomes of accidents, incidents and near misses that may influence ward practices is implemented.	senior nurse manager and Cranfield ward managers. Accidents, incidents and near misses were reviewed at the unit meetings.	

Appendix 1

Follow-up on recommendations made following the patient experience interview inspection on 11 June 2014

No.	Reference.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1		N/A		

Follow-up on recommendations made at the finance inspection on 31 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 all staff who obtain the key to the drawers where patient's money is stored is kept, including the reason for access.	The inspector reviewed records in relation to patients' finances. There was a record of all staff who obtain the key to the drawers where patients money is stored and this included the reason for access.	Fully met

Follow up on the implementation of any recommendations made following the investigation of a Serious Adverse Incident

No.	SAI No	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1		N/A		

Quality Improvement Plan

Unannounced Inspection

Cranfield Female, Muckamore Abbey Hospital

2 & 3 February 2015

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

The specific actions set out in the Quality Improvement Plan were discussed with the ward sister, hospital staff, senior management and other trust personnel on the day of the inspection visit.

Any matters that require completion within 28 days of the inspection visit have also been set out in separate correspondence to the senior manager.

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	5.3.3 (b)	It is recommended that the ward sister ensures that risk assessments and care plans are discussed with the patient and / or their carers where appropriate. This should be evidenced within the care documentation.	2	Immediate and on-going	In response to this recommendation, the Ward Sister carries out monthly internal audits within the ward to monitor care documentation. Evidence of the patient and /or their carers involvement in risk assessments and care plans is monitored as part of this audit.
2	5.3 (f)	It is recommended that the trust ensures that all care documentation is accurate, current, personalised and in keeping with relevant published professional guidance documents including NMC Record keeping guidance and DHSSPSNI 2010 Deprivation of Liberty Safeguards (DOLS) – Interim Guidance.	2	Immediate and on-going	In response to this recommendation, the trust ensures all care documentation is accurate, current, personalised and in keeping with relevant published professional guidance documents including NMC Record keeping guidance and DHSSPSNI 2010 Deprivation of Liberty Safeguards (DOLS) – Interim Guidance through the monitoring of care documentation by monthly internal audits within the ward.
3	5.3.3 (b)	It is recommended that the ward sister ensures that a rationale is recorded where patients and or their representatives are not involved in their risk assessments. This rationale should reflect the patients' level	1	Immediate and on-going	In response to this recommendation, the Ward Sister carries out monthly internal audits within the ward to monitor care documentation. Evidence of the patient and /or their carers involvement in risk assessments is monitored as part of this audit. Where the patient or their representatives are not

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
		of understanding and demonstrate that all reasonable adjustments have been made to support the patient to understand their care and treatment plans.			involved in their risk assessments, a rationale is detailed to reflect the reasons. The rationale reflects the patients' level of understanding and demonstrates that all reasonable adjustments have been made to support the patient
4	5.3.1 (a)	It is recommended that the ward sister ensures that activities that are used as proactive strategies as documented in patients behaviour support plans are implemented.	1	Immediate and on-going	In response to this recommendation, the ward Sister has reinforced with staff the need to implement activities used as proactive strategies as detailed in individual behaviour support plans. This is evidenced through the patients progress notes.
5	5.3.3 (b)	It is recommended that the ward sister ensures that patients who are not attending Moyola day care have access to a range of individualised and group therapeutic and recreational activities. A reason should be documented when these are unavailable or patients do not participate.	1	Immediate and on-going	In response to this recommendation the Ward Sister and ward staff have updated the patients assessment to reflect preferred activites. An activity schedule, detailing available activities has been drawn up and is displayed on the ward. Each patient also has an individualised activity schedule based on their assessed need and available activities. Staff document patients participation in the progress notes. Patients non participation is also documented, detailing the reasons for non

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No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
					participation. This includes the reason why activities may not be available.
6	6.3.2 (c)	It is recommended that the ward sister ensures that all information displayed in the ward meets the communication needs of all the patients. (Lay assessor recommendation)	1	3 July 2015	In response to this recommendation the Ward Sister has liaised with the patients forum and the patients council to ascertain what information patients want and how patients need information displayed. The ward Sister is also liaising with Speech & Language Therapy to assist in producing information for display.

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	Adrienne Creane
NAME OF CHIEF EXECUTIVE / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Martin Dllon

Inspector assessment of returned QIP				**Inspector**	**Date**
		Yes	**No**		
A.	Quality Improvement Plan response assessed by inspector as acceptable	✓		Wendy McGregor	**26 March 2015**
B.	Further information requested from provider				