The Regulation and Quality Improvement Authority

Cranfield ICU

Muckamore Abbey Hospital

Belfast Health and Social Care Trust

Unannounced Inspection Report

Date of inspection: 13 May 2015

npm national preventive mechanism

Contact:

informing and improving health and social care

www.rqia.org.uk

Ward address: Muckamore Abbey Hospital, 1 Abbey Road, Muckamore Co.Antrim

Ward Manager: Sean Murray

Telephone No: 02894662608

E-mail: team.mentalhealth@rqia.org.uk

RQIA Inspectors: Audrey McLellan and Kieran McCormick

Telephone No: 02890517500

Our Vision, Purpose and Values

Vision

To be a driving force for improvement in the quality of health and social care in Northern Ireland

Purpose

The Regulation and Quality Improvement Authority (RQIA) is the independent health and social care regulator in Northern Ireland. We provide assurance about the quality of care, challenge poor practice, promote improvement, safeguard the rights of service users and inform the public through the publication of our reports.

Values

RQIA has a shared set of values that define our culture, and capture what we do when we are at our best:

- **Independence** - upholding our independence as a regulator
- **Inclusiveness** - promoting public involvement and building effective partnerships - internally and externally
- **Integrity** - being honest, open, fair and transparent in all our dealings with our stakeholders
- **Accountability** - being accountable and taking responsibility for our actions
- **Professionalism** - providing professional, effective and efficient services in all aspects of our work - internally and externally
- **Effectiveness** - being an effective and progressive regulator - forward-facing, outward-looking and constantly seeking to develop and improve our services

This comes together in RQIA's Culture Charter, which sets out the behaviours that are expected when employees are living our values in their everyday work.

Contents

1.0 Introduction

The Regulation and Quality Improvement Authority (RQIA) is the independent health and social care regulator in Northern Ireland. We provide assurance about the quality of care, challenge poor practice, promote improvement, safeguard the rights of service users and inform the public through the publication of our reports.

RQIA's programmes of inspection, review and monitoring of mental health legislation focus on three specific and important questions:

Is Care Safe?

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

Is Care Effective?

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

Is Care Compassionate?

- Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support

2.0 Purpose and Aim of this Inspection

To review the ward's progress in relation to recommendations made following previous inspections.

To meet with patients to discuss their views about their care, treatment and experiences.

To assess that the ward physical environment is fit for purpose and delivers a relaxed, comfortable, safe and predictable environment.

To evaluate the type and quality of communication, interaction and care practice during a direct observation using a Quality of interaction Schedule (QUIS).

2.1 What happens on inspection

What did the inspector do:

- reviewed the quality improvement plan sent to RQIA by the Trust following the last inspection(s)

- talked to patients, carers and staff
- observed staff practice on the days of the inspection
- looked at different types of documentation

At the end of the inspection the inspector:

- discussed the inspection findings with staff
- agreed any improvements that are required

After the inspection the ward staff will:

- send an improvement plan to RQIA to describe the actions they will take to make any necessary improvements

3.0 About the ward

Cranfield ICU is a six bedded mixed gender ward. The purpose of the ward is to provide assessment and treatment to patients with a learning disability who need to be supported in an intensive care environment. On the days of the inspection all six patients on the ward were detained under the Mental Health (Northern Ireland) Order 1986. There were three patients whose discharge from hospital was delayed.

Patients receive input from a multidisciplinary team which includes a consultant, nursing staff, two doctors, a psychologist, a behaviour support nurse and a social worker. A patient advocacy service is also available.

The ward manager was in charge of the ward on the day of the inspection.

4.0 Summary

Progress in implementing the recommendations made following the previous inspection carried out on 25 & 26 September 2014 were assessed during this inspection. There were a total of 34 recommendations made following the last inspection.

It was good to note that 31 recommendations had been implemented in full.

However, three recommendations had been partially met and will be restated for a second time following this inspection.

The inspector was pleased to note that all records reviewed were accurate, current and in keeping with relevant published professional guidance documents. There was evidence that care plans, comprehensive risk assessments, nursing assessments and positive behaviour support plans had been reviewed regularly. Progress notes reviewed by the inspectors were detailed and gave a comprehensive account of each patient's progress on the ward. There was evidence that patients' capacity to consent to care and treatment was reviewed regularly by staff and documented. It was good to note that a psychologist was now part of the MDT and patients had access to

speech and language therapy. The Trust had also reviewed the level of medical staff available to the ward and there was now daily medical support available for patients.

The inspectors assessed the ward's physical environment using a ward observational tool and check list. The environment appear relaxed, comfortable, clean and clutter free. There was ample natural lighting, good ventilation and the ward furnishings were well maintained. All patients had their own private bedroom with ensuite. There were rooms available for patients to have quiet time on their own and there was areas in the main part of the ward for patients to spend time in the company of others. The ward had access to a garden area which was well maintained and was available for patients to access freely throughout the day.

During the inspection the inspectors completed a direct observation using the Quality of Interaction Schedule (QUIS) tool. This assessment rated the quality of the interactions and communication that took place on the ward between patients, nursing staff and ward professionals. Overall the quality of interactions between staff and patients were positive.

During the inspection the inspectors spoke to two patients who had agreed to meet with them to complete a patient experience questionnaire. This recorded their experience in relation to the care and treatment they had received on the ward. Both of these patients made positive comments about how they had been treated on the ward.

4.1 Implementation of Recommendations

Three recommendations which relate to the key question "**Is Care Safe**?" were made following the inspection undertaken on 25 & 26 September 2014

These recommendations concerned how comprehensive risk assessments had been completed and who had contributed to these assessments to ensure that these were completed in accordance with the Promoting Quality Care guidance. Another concern was the availability of screening for patients' physical health care needs.

The inspector was pleased to note that two recommendations had been fully implemented.

- Patients had comprehensive risk assessments in place which had been completed in accordance with guidance.
- Comprehensive risk assessments detailed the use of the restrictive practices and outlined the basis on which these decisions had been made

However, despite assurances from the Trust, one recommendation had not been fully implemented. Clinical resources were not available to ensure

patients had access to screening with regard to their physical/primary health care needs. This recommendation will be restated for a **second time** following this inspection.

There were 23 recommendations which relate to the key question "**Is Care Effective**?" made following the inspection undertaken on 25 & 26 September 2014

These recommendations concerned supervision records, signing and review of risk assessments, training for staff in relation to deprivation of liberty safeguards, human rights and capacity and consent. Recommendations had also been made in relation to the completion of documentation which included records of patients' capacity and consent to treatment, comprehensive assessments, care plans and positive behaviour support plans. There were concerns in relation to patients not having assessments completed for individual therapeutic/recreational activities and records had not been maintained with regard to patients' participation in therapeutic activities.

Recommendations had also been made following this inspection regarding the availability of and patient access to psychology, speech and language therapy, medical staff and occupational therapy. The was no evidence at that time that patients' relatives, and where appropriate advocates, had been involved in decisions with regard to restrictive practices that were in place. Concerns were also noted in relation to the lack of care planning with regard to patients' discharge. The mix of patients on the ward had also been raised as a concern with patients ready for resettlement into the community on the ward with patients who required acute assessment.

The inspector was pleased to note that 21 recommendations had been fully implemented and improvement was noted in the following areas:

- Action plans following supervision sessions were recorded, agreed and monitored
- Risk assessments had been sign by all professionals, relatives/carers and patients who had been involved in the assessment.
- Staff had received training in deprivation of liberty and human rights.
- All documentation reviewed was accurate, current and in accordance with professional guidance documents
- Patients capacity to consent to care and treatment was recorded and regularly reviewed
- Comprehensive assessments were up to date and had been developed in partnership with patients and their carers/relatives
- Care plans were person centred and were used to inform and guide the care and treatment interventions on the ward

- Patients had positive behaviour support plans in place which were up to date and linked to patient's care plans

- A fulltime psychologist had been recruited and was working as part of the MDT

- Patients had individual assessments completed for aspects of care including therapeutic activities. Records were maintained of patients progress and participation in these activities

- Patients' relatives/carers and when appropriate advocates were given the opportunity to be involved in decisions with regard to the use of restrictive practices.

- Care plans were in place in relation to discharge planning

- Patients and their carers/relatives were aware of the advocacy services.

- The Trust had reviewed the mix of patients on the ward

However, despite assurances from the Trust, two recommendations had not been fully implemented. These recommendations will be restated for a **second time** following this inspection.

All staff had not received training in relation to capacity and consent. An occupational therapist (OT) was not part of the multidisciplinary team, therefore there was no OT involved in reviewing patients' progress or in completing assessments on the ward which would direct the therapeutic and recreational activities for patients.

Eight recommendations which relate to the key question "**Is Care Compassionate**?" were made following the inspection undertaken on 25 & 26 September 2014.

These recommendations concerned the emergency alarm system being linked to other wards on the hospital site, care plans in relation to deprivation of liberty not being clear with regard to the restrictions imposed on patients. There was no evidence of best interest meetings held when patients had been assessed as lacking capacity to make decision regarding their care and treatment. Lack of consideration on the impact of patients' human rights when completing assessments and developing care interventions was also a concern. Care plan were not in place which detailed the management of distressed reactions and triggers which may suggest deterioration in a patient's behaviour and there was no evidence that patients and their relatives/carers had been involved in discharge plannings meeting.

The inspector was pleased to note that all eight recommendations had been fully implemented and improvement was noted in the following areas:

- Deprivation of Liberty Safeguards (DOLS) had been implemented on the ward.
- The alarm system had been reviewed and up dated to ensure that alarms from other wards on the hospital site could not be heard on the ward
- Care plans had been developed which detailed the rationale for the level of restriction in terms of necessity and proportionality. Consideration of the impact on patient's human rights was also included in these care plans.
- Patients' capacity to consent to care and treatment was reviewed regularly on the ward.
- Consideration had been given to the impact of restrictive practices on patients' Human Rights articles 5, 8 and 14.
- Care plans detailed in relation to restrictive practices were completed and included the rationale for the level of restriction in terms of necessity and proportionality.
- Consideration of the impact on patient's human rights was included in care plans
- Patients and their relatives/carers were involved in discharge planning

The detailed findings from the follow up of previous recommendations are included in Appendix 1

5.0 Ward Environment

"A physical environment that is fit for purpose delivering a relaxed, comfortable, safe and predictable environment is essential to patient recovery and can be fostered through physical surroundings." Do the right thing: How to judge a good ward. (Ten standards for adult-in-patient mental health care RCPSYCH June 2011)

The inspectors assessed the ward's physical environment using a ward observational tool and check list.

Summary

The inspectors noted that there was information provided in the welcome to Cranfield PICU welcome pack; this was also available in an easy to read format. There was no information displayed in relation to the ward performance.

The inspectors reviewed two weeks staffing rota for the ward; no concerns were identified from the review of ward rotas. Staffing levels appeared adequate to support the assessed needs of the patients. Staff were observed to be attentive and assisted patients promptly when required. Staff were observed supporting patients with recreational activities.

The ward environment was clean and clutter free. There was ample natural lighting, good ventilation and neutral odours. Ward furnishings were well maintained and comfortable.

The ward environment promoted patients' privacy and dignity. Patients had their own individual ensuite bedrooms. Additional bathroom and toilet facilities were accessible. Patients could lock bathroom doors and a call system was available. There was a private room off the main ward area for patients to meet with their visitors. The entrance doors to the ward were locked at all times. A cordless phone was available for patient access.

There were no areas of overcrowding observed on the day of the inspection; the day areas were open, spacious and the furniture was arranged in a way that encouraged social interaction. There were smaller areas for patients to sit and form friendships. The inspectors observed that staff were present at all times in the communal areas and available at patients' request. A well maintained outside area was noted to be open and accessible throughout the inspection.

Confidential records were stored appropriately and patient details were not displayed. Signage was available throughout the ward, this included makaton signage.

There was up to date and relevant information displayed in a format that met the patients' communication needs both in the communal areas and available in the ward welcome / information pack. This included the following information; Human Rights, patient rights in accordance with the Mental Health (Northern Ireland) Order 1986, the right to access patient information, independent advocacy services and the right to make a complaint. Information was also available in easy read format. Information in relation to deprivation of liberty was displayed in patient communal areas.

The inspectors visited the medical room and noted that it was clean, tidy and well organised. Emergency equipment was centrally stored between all Cranfield wards.

Patient activities and day care schedules were displayed in patients' bedrooms and also on a notice board on the ward. The date, time and weather were also communicated on the notice board.

Patients were observed during lunch time in a clean and comfortable dining area which was incorporated within the main ward sitting area. Meal times were protected and patients were given time to eat. A choice of meals was

available and staff were observed offering patients choice. Meals appeared appetising. Staff were observed during the inspection intermittently offering patients a choice of tea, coffee or juice. The inspectors noted that staff were warm, friendly and respectful of patients. Patients appeared at ease and comfortable.

The inspectors reviewed the seclusion facility on the ward. The seclusion room was off the main ward area accessible via two doors. The room appeared large enough to facilitate more than six staff and a patient. The room was furnished with only a large mattress. There were no obvious areas in the seclusion room that could cause injury or harm. The room was clean, well lit with good ventilation. The walls were painted a neutral colour; there were facilities for the patient to view outside with plenty of natural light also coming into the room. The bathroom was located next door to the seclusion room. Staff monitor the room through the window in the door. Staff working on Cranfield ICU carry individual mobile staff alarms. The inspectors were concerned that the door to the seclusion room was locked manually by staff and did not open automatically if the fire alarm was triggered. A recommendation has been made in relation to this

The inspectors identified other areas which should be reviewed by the ward manager to improve standards on the ward in accordance with good practice guidance. These include:

- Installing a blind on the outside of the glazed door to the seclusion room which can be controlled by staff.
- Displaying information about the ward's performance e.g. information in relation to incidents, compliments and complaints.
- All staff on duty should wear names badges.
- Details of the ward round, ward doctor and other members of the multi-disciplinary team should be displayed on the notice boards.
- The name of the patients' named nurse should be displayed as well as the name of the staff member who has been allocated the time to provide one to one support
- Information should be displayed of when the next patient forum meeting will be held

The detailed findings from the ward environment observation are included in Appendix 2

6.0 Observation Session

Effective and therapeutic communication and behaviour is a vitally important component of dignified care. The Quality of Interaction Schedule (QUIS) is a

method of systematically observing and recording interactions whilst remaining a non- participant. It aims to help evaluate the type of communication and the quality of communication that takes place on the ward between patients, staff, and visitors.

The inspector completed a direct observation using the QUIS tool during the inspection and assessed whether the quality of the interaction and communication was positive, basic, neutral, or negative.

Positive social (PS) - care and interaction over and beyond the basic care task demonstrating patient centred empathy, support, explanation and socialisation

Basic Care (BC) – care task carried out adequately but without elements of psychological support. It is the conversation necessary to get the job done.

Neutral – brief indifferent interactions

Negative – communication which is disregarding the patient's dignity and respect.

Summary

The formal session involved observations of interactions between staff and patients/visitors. Six interactions were noted in this time period. The outcome of these interactions were as follows:

Positive	Basic	Neutral	Negative
50%	33%	16%	0%

Overall the quality of interactions between staff and patients were positive. Patients and nursing staff were observed sitting together in the communal area. The atmosphere was relaxed for most of the day and all patients appeared in good spirits. Staff were available and prompt in assisting patients throughout the observations.

The detailed findings from the observation session are included in Appendix 3

7.0 Patient Experience Interviews

Two patients agreed to meet with the inspectors to talk about their care, treatment and experience as a patient. Both patients agreed to complete a questionnaire regarding their care, treatment and experience as a patient. All patients who met with the inspector had been detained in accordance with the Mental Health (Northern Ireland) Order 1986.

Responses to the questions asked were varied:

- One of the two patients who met with the inspectors said they felt safe; however both patients said they knew what to do if they were unhappy.
- Both patients knew who their doctor and nurse was.
- The patients who met with the inspectors both stated they were well cared for.
- The patients felt that they had enough to do to keep them busy.
- Patients confirmed that they got time off the ward and staff had time to talk to them.
- Patients were aware of the locked doors on the ward.

Patients made the following comments:

"I would like a key to my own room"

"staff are good to me"

The inspection was unannounced. No relatives or carers were available to meet with inspectors during the inspection.

8.0 Other areas examined

During the course of the inspection the inspector met with:

Ward Staff	**3**
Other ward professionals	**2**
Advocates	**0**

Wards staff

The inspectors met and spent time with three members of nursing staff on the day of inspection. Staff who met with the inspectors did not express any concerns regarding the ward or patients' care and treatment.

Other ward professionals

The inspectors met with two visiting professionals to the ward on the day of the inspection.

The inspectors met with the ward social worker who provided an overview of the progress and preparation for discharge for the patients on the ward. The social worker provided the inspector with an update in relation to each patient. The ward social worker did not express any concerns regarding the ward or patients' care and treatment. The ward social worker stated:

"staff work great as a team"

The inspectors met with the Behaviour Nurse Specialist for the ward. The behaviour nurse provided the inspectors with a summary of their role and of the role of the behaviour support team. The behaviour nurse explained in detail the variety of work they undertake with patients on the ward. The behaviour nurse did not express any concerns regarding the ward or patients' care and treatment. Comments made by the the behaviour nurse included:

"an enthusiastic team, keen to take on new ideas and willing to listen"

The inspection was unannounced. No advocates were available to meet with the inspectors during the inspection.

9.0 Next Steps

A Quality Improvement Plan (QIP) which details the areas identified for improvement has been sent to the ward. The Trust, in conjunction with ward staff, must complete the QIP detailing the actions to be taken to address the areas identified and return the QIP to RQIA by 8 July 2015

The lead inspectors will review the QIP. When the lead inspectors are satisfied with actions detailed in the QIP it will be published alongside the inspection report on the RQIA website.

The progress made by the ward in implementing the agreed actions will be evaluated at a future inspection.

Appendix 1 – Follow up on Previous Recommendations

Appendix 2 – Patient Experience Interview

Appendix 3 – Ward Environment Observation
(This document can be made available on request)

Appendix 4 – QUIS
(This document can be made available on request)

Appendix 1

Follow-up on recommendations made following the unannounced inspection on 25 & 26 September 2014

No.	Reference.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	4.3. (i)	It is recommended that the ward manager ensures that action plans following supervision are recorded, agreed and monitored.	The inspectors reviewed supervision records. Action plans following supervision sessions were recorded, agreed and monitored. A timetable had been completed which set out the dates each staff member had supervision and a date with the next planned session. All staff on the ward had up to date supervision in place on the days of the inspection.	Fully Met
2	5.3.1 (a)	It is recommended that the ward manager ensures the signing off and review of risk assessments are monitored.	The inspector reviewed three sets of care documentation and there was evidence in all three records that patients' risk assessments had been signed and reviewed regularly at the multi-disciplinary team. Patients and carers had also signed this document and if they had not been able to sign this was recorded with the reasons why. In all three risk assessments reviewed by the inspectors there was evidence of the staff who had contributed to the risk assessment and had signed this document. The inspectors reviewed records of monthly audits completed by the ward manager. This audit reviewed patients' risk assessments to ensure each assessment had been completed in accordance with the Promoting Quality Care- Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services May 2010	Fully met
3	4.3 (m)	It is recommended that staff within Cranfield ICU receive awareness training on their role in relation to Deprivation of Liberty Safeguards (DOLS) – Interim Guidance, as outlined by the DHSSPSNI in	The inspectors reviewed training records for the ward. There was evidence that all staff had up to date mandatory training in place which included deprivation of liberty safeguard training (DOLS). However since January four new staff members had taken up post on the ward and were still to receive training in relation to DOLs. Plans were in place for these four staff	Fully met

		October 2010.	members to attend training in the next month.	
4	4.3 (g)	It is recommended that Deprivation of Liberty Safeguards (DOLS) – Interim Guidance, as outlined by the DHSSPSNI in October 2010, is implemented within Cranfield ICU.	The inspectors reviewed three sets of care documentation which contained a summary in relation to the individual deprivation of liberty in place for each patient. From this summary care plans had been developed which detailed the rationale for the level of restriction in terms of necessity and proportionality. Consideration of the impact on patient's human rights was also included in these care plans.	Fully met
5	4.3.(g)	It is recommended that all care documentation is accurate, current and in keeping with relevant published professional guidance documents including NMC Record keeping guidance and DHSSPSNI 2010 Deprivation of Liberty Safeguards (DOLS) – Interim Guidance.	In all three sets of care documentation reviewed by the inspectors there was evidence that records were accurate, current and in keeping with relevant published professional guidance documents. All records were up to date and there was evidence that care plans, risk assessments and positive behaviour plans had been reviewed regularly. Multi-disciplinary team meetings (MDT) were held weekly on the ward and MDT records detailed the discussions held with the outcome and planned action. Progress notes reviewed by the inspectors were detailed and gave a comprehensive account of each patient's progress on the ward. A summary in relation to the individual deprivation of liberty in place for each patient was completed and from this care plans had been developed which detailed the rationale for the level of restriction in terms of necessity and proportionality. Consideration of the impact on patient's human rights was also included in these care plans.	Fully met
6	5.3.1 (f)	It is recommended that information and correspondence relating to patient care and treatment is	The inspector reviewed three sets of care documentation and there was evidence that information and correspondence relating to patients' care and treatment was recorded clearly in	Fully met

		recorded clearly in the patient's care documentation to ensure accuracy	the patient's care documentation. No concerns were noted regarding any aspects of the three patients care documentation.	
7	5.3.1.(f)	It is recommended that the ward manager ensures the staff assistance emergency alarm within the Cranfield unit is reviewed.	The alarm system has been updated. The inspectors were informed that when the alarm is raised in other wards on the Cranfield site it is not heard within the ICU. On the day of the inspection the inspectors did not hear any alarms from other wards and patients did not raise any concerns in relation to the alarm system.	Fully met
8	5.3.1. (a)	It is recommended that the ward manager ensures that all care plans in place which detail restrictive practices have a clear rationale for the restriction in place in terms of necessity and proportionality.	The inspectors reviewed three sets of care documentation which contained a summary in relation to the individual deprivation of liberty in place for each patient. From this summary care plans had been developed which detailed the rationale for the level of restriction in terms of necessity and proportionality. Consideration of the impact on patient's human rights was also included in these care plans.	Fully met
9	5.3.1 (f)	It is recommended that the ward manager ensures that patients' capacity to consent to care and treatment is monitored and re-evaluated regularly throughout their admission.	The inspectors were advised by the ward manager that patients' capacity to consent is monitored and evaluated throughout the patients' time on the ward; this was evidenced in the patients care plans, MDT records and progress notes. All three patients had assessments completed in relation to their ability to manage their own finances.	Fully met
10	5.3.1 (f)	It is recommended that the ward manager ensures that patients who have been assessed as lacking capacity to make decisions regarding there care and treatment, have a multidisciplinary discussion regarding best interest decisions. As outlined in the DHSSPS March 2003 References	There was evidence in the three sets of care documentation reviewed by the inspectors that patient consent to care and treatment was assessed and recorded in their assessment of need. The ward manager advised that there were no patients on the ward who had been assessed as not having capacity to make decisions regarding their care and treatment. In the three sets of care documentation reviewed there was evidence that	Fully met

		Guide to Consent for Examination, Treatment or Care.	patients' capacity to consent to care and treatment was reviewed regularly. The ward manager advised that if concerns are raised regarding patients ability to make decisions they are assessed on the ward and best interest meetings were held. Invites are provided to the patients' family/carers and all relevant professionals including the patients' advocate if this is deemed appropriate so that best interest decisions can be made in relation to the patients' care and treatment	
11	7.3(c)	It is recommended that the ward manager ensures that consideration is given to the impact of restrictive practices on patients Human Rights articles 5, 8 and 14 when undertaking assessments and developing care interventions to address identified needs.	In the three sets of care documentation reviewed by the inspector there was evidence that consideration had been given to the impact of restrictive practices on patients' Human Rights articles 5, 8 and 14. This was detailed in patients' individual summary of restrictive practices and in each patient's individual restrictive practice care plans.	Fully met
12	7.3 (c)	It is recommended that the Trust ensures that all staff receive training in relating to promoting and upholding the Human Rights of patients.	The inspector review training records for the ward. There was evidence that all staff had up to date mandatory training in place which included Human Rights training. However since January four new staff members had taken up post on the ward and were still to receive training in relation to Human Rights. Plans were in place for these four staff members to attend training in the next month.	Fully met
13	4.3 (m)	It is recommended that the Trust ensures that all staff receive training in relation to capacity to consent to care and treatment to include an understanding of the DHSSPS guidance on decision	The inspector review training records for the ward. There was evidence that eight out of the 22 staff members on the ward did not have capacity to consent training. Plans were in place for these eight staff members to attend training however no dates had been confirmed	Partially met

		making and consent for patients who do not have capacity to consent.	This recommendation will be restated for a second time	
14	5.3.1 (f)	It is recommended that the ward manager ensures all information regarding the patients/relatives attendance and input in multi-disciplinary meetings is recorded.	The ward had devised a new multi-disciplinary team template for recording these meetings. This included who had attended the meeting, patients and carer/relative views, actions from previous meetings and actions agreed. There was also a section on whether feedback was given to patients and their responses and if feedback had been given to carers/advocates and there comments. In the three sets of care records reviewed these sections had been completed in full.	Fully met
15	5.3.1 (a)	It is recommended that the ward manager ensures that all patients have an up to date comprehensive assessment in place which has been developed in partnership with the patient and their relative/carer if appropriate.	In the three sets of care records reviewed all patients had up to date comprehensive assessments in place. There was evidence that these assessments had been developed in partnership with the patient and their relative/carer.	Fully met
16	5.3.1 (a)	It is recommended that the ward manager ensures that all care plans are person centred and are used to inform and guide care and treatment interventions on the ward.	In the three sets of care records reviewed there was evidence of person centred care plan which had been devised from the patients' assessed need. These care plans were used to inform and guide care and treatment interventions on the ward and were linked to positive behaviour support plan. There was evidence that care plans were reviewed on a regular basis and had been completed in partnership with the patients.	Fully met
17	5.3.1 (a)	It is recommended that the ward manager ensures that all patients are screened to see if they require	In all three sets of care documentation reviewed there was evidence that patients had been screened to ascertain if they require a comprehensive risk assessment in place. In all three	Fully met

		a comprehensive risk assessment in place. These assessments should be completed by the multi-disciplinary team detailing the use of the restrictive practices outlining the basis on which the decisions have been taken. Emphasis should be on developing an intervention to reduce this level of restriction using a skills development and recovery based approach.	sets of care documentation it was recorded that all these patients required a comprehensive risk assessment to be completed and these were in place for two of the patients. One patient had recently transferred from a children's ward and had a FACE risk assessment in place. The MDT had completed a risk screening tool and were in the process of completing a comprehensive risk assessment. Each assessment had been signed by each member of the multi-disciplinary team and by the patient's carer/relative and the patient. All three assessments reviewed detailed the use of the restrictive practices outlining the basis on which the decisions have been taken. These restrictions were reviewed on a weekly basis at the MDT to ensure that the least restriction practice was in place. All three patients had an up to date positive behaviour support plan in place which was linked to the patients comprehensive risk assessment.	
18	5.3.3 (b)	It is recommended that the ward manager ensures that patients and where appropriate their relatives/carers have the opportunity to contribute to the comprehensive risk assessment and sign this document. As outlined in the Promoting Quality Care Guidance Document – Good Practice on the Assessment and Management of Risk in Mental Health and Learning Disability Services- May 2010.	In the three sets of care documentation reviewed there was evidence that patients and their carers/relative when appropriate had been involved in completing the risk screening tool and the comprehensive risk assessments. Two of these documents had been signed by the patient and their relative/carers. One comprehensive risk assessment was completed in the previous ward which was the FACE risk assessment as the patient had recently transferred from a children's ward. The MDT had completed a risk screening tool and were working on completing a comprehensive risk assessment.	Fully met

19	5.3.1 (f)	It is recommended that the ward manager ensures that the correct names of patients are recorded in all care documentation and that all records relating to patients are stored in the correct patients file.	In the three sets of care documentation reviewed the inspectors noted that the correct names of patients were recorded in all care documentation and all records relating to patients were stored in the correct patient's file.	Fully met
20	5.3.1 (a)	It is recommended that the ward manager ensures that interventions to address individual patient's behavioural presentation are current and that the implementation of such interventions is evaluated and records are in place to evidence progress.	In the three sets of care documentation reviewed there was evidence of positive behaviour support plans in place for each patient, which had recently been reviewed and updated. These plans were linked to each patient's care plans and there was evidence in the patients' progress notes that patients' progress in relation to these plans was monitored and reviewed on a regular basis to record patients' progress.	Fully met
21	6.3.1 (a)	It is recommended that the Trust reviews the availability of and access to clinical psychology for patients on the ward.	A fulltime psychologist has been recruited and is currently working as part of the MDT. There was evidence in two sets of care documentation reviewed that the psychologist had commenced work with patients (management of anxiety issues and dialectical behaviour therapy (DBT).	Fully met
22	5.3.1 (a)	It is recommended that the ward manager ensures that patient access to and participation in therapeutic activities is recorded in the patients care documentation to ensure ongoing monitoring and evaluation of all aspects of care and treatment.	In the three sets of care documentation reviewed there was evidence that patients had access to and participation in therapeutic activities. There was evidence that staff had recorded patient's progress when they had been involved in activities on the ward to monitored and evaluated patient progress and participation. There was evidence of meetings held with day care staff on the hospital site to review patients' progress in the day centre and to discuss and plan further activities for patients to participate in.	Fully met
23	5.3.1 (a)	It is recommended that the ward manager ensures that patients	In the three sets of care records reviewed patients had individualised comprehensive assessments and positive	Fully met

		have individualised assessments completed for aspects of care including therapeutic and recreational activities.	behaviour support plans completed by nursing staff and the behaviour support nurse. From these assessments therapeutic and recreational activities had been set up for each patient. In the three sets of care records reviewed each patient had an individual therapeutic and recreational timetable in place. A copy of this timetable was also displayed in the patients bedrooms in easy read format.	
24	5.3.1. (a)	It is recommended that the ward manager ensures that all care plans in place which detail restrictive practices have a clear rationale for the restriction in place in terms of necessity and proportionality.	The inspectors reviewed three sets of care documentation which contained a summary in relation to the individual deprivation of liberty in place for each patient. From this summary care plans had been developed which detailed the rationale for the level of restriction in terms of necessity and proportionality. Consideration of the impact on patient's human rights was also included in these care plans	Fully met
25	5.3.3 (b)	It is recommended that the ward manager ensures that patients, relatives and were appropriate advocates are given the opportunity to be involved in assessments and decisions with regard to the use of restrictive practices.	There was evidence in the three sets of care documentation reviewed by the inspectors that patients, relatives/carers had been given the opportunity to be involved in assessments and decisions with regard to the use of restrictive practices. Patients and relatives/carers had signed the restrictive practice summary which detailed each deprivation that was in place. If they were unable to sign an explanation was recorded. All care plans had been transferred to the new electronic recording system (PARIS) therefore patients were unable to sign these plans however patients and their carers/relative had signed the comprehensive risk assessments which detailed restrictive practices. These practices were reviewed at the MDT meetings and patients and their relatives/carers were given an opportunity to contribute to these meetings.	Fully met

26	8.3 (i)	It is recommended that the ward manager ensures that care plans in relation to discharge planning are developed and that progress and actions relating to discharge planning are recorded in the care documentation.	In the three sets of care documentation reviewed each patient had a care plan in place which detailed the patients' discharge plans. Progress and actions in relation to discharge was recorded in the patients' MDT records and in the patients' progress notes.	Fully met
27	8.3 (i)	It is recommended that the ward manager ensures that patients' relatives/carer are invited and involved in discharge planning meetings where appropriate. If they are unable to attend this should be recorded. A record of how this information will be shared with patients' relatives/carers should be included in the patient's care documentation.	The inspectors spoke to the social worker attached to the ward who advised that they record all details of patients' discharge in the patients' progress notes and they also attend the weekly MDT meetings. The social worker advised that there were three patients on the ward whose discharge was classed as delayed as there were no suitable placements available in the community. The ward manager advised that in the majority of cases patients would transfer back to the ward they had transferred from and would not usually be discharged from the ICU unit. However in the case of these three particular patients it had been recommended by the MDT that they continue to stay in the ICU ward until they are discharged. The social worker for the ward advised that they were planning a meeting with two of the patients' community workers to discuss and plan for the patients' discharge. When an appropriate placement is agreed as suitable they plan to hold meetings with the patients and their relatives/carers to discuss the various options available. There were plans in place for one patient to transfer to another hospital under an extra contractual referral (ECR). There was	Fully met

			evidence in this patient's care records that indicated the reasons why the patients' relatives/carer were not invited and involved in the discharge planning for this patient. There was also evidence that this patient had also not been involved in meetings regarding this transfer. However, the reason for this was clearly documented and there were plans in place to involve the patient at a later stage of the process.	
28		It is recommended that the Trust ensures that positive behaviour support strategies used on the ward to address behaviours that challenge promote development of alternative functional positive behaviours.	In the three sets of care documentation reviewed by the inspectors there was evidence that each patient had an up to date positive behaviour support plan (PBS) in place. These plans detailed the patient's background and their current presentation. Each plan identified were the information was sourced from to complete the PBS plan i.e. functional assessments, speech and language therapy reports, MDT discussions, medical records, psychology records and through observations. There was a record in each PBS plan of the behaviours each patient can display which can be challenging and the triggers to these behaviours being displayed. The cycle of behaviour was detailed with the early warning signs. The function of the behaviour was also detailed. The traffic light system had been implemented and support strategies were in place around this system. Behaviours were recorded with specific support strategies to stop the situation from escalating further and to assist the patient in returning to the proactive stage as soon as possible.	Fully met
29	6.3.2 (a)	It is recommended that the ward manager ensures that all patients and relatives/carer are aware of the advocacy service on the ward.	The inspectors observed posters on the walls in the ward which detailed the advocacy service available for patients. (Mencap and Bryson House). The ward manager advised that all patients had been referred to an advocacy service. The name of the	Fully met

			advocate for each patient was recorded in each patient's nursing assessment.	
30	6.3.1 (a)	It is recommended that the Trust reviews the availability of and access to of occupational therapy and speech and language therapy in Cranfield ICU.	The Trust had reviewed the availability of speech and language therapy on the ward and patients were able to access this service through a referral system. There was evidence in the patients' records that speech and language assessments had been completed for patients when required. Patients who attended the day care centre on the hospital site had access to OT and staff could gain advice from this service for these patients. However the availability of occupational therapy (OT) for the ward is through a referral system and is only available for functional assessments. There is no OT attached to the MDT and therefore there is no OT involved in reviewing patients' progress or in completing assessments on the ward which would direct the therapeutic and recreation activities for patients on the ward A new recommendation will be made in relation to this	Partially met
31	6.3.1 (a)	It is recommended that the Trust reviews the current mix of patients who are in Cranfield ICU for acute assessment and treatment and patients who are ready for resettlement into the community.	The ward manager advised that the mix of patients on the ward is continually reviewed. It has been decided that three of the patients who are delayed in their discharge should stay in the unit due to their individual need.	Fully met
32	6.3.1 (a)	It is recommended that the Trust reviews the medical staffing level availability for the ward.	The Trust has reviewed the medical staffing levels available to the ward. There is now one consultant who is attached to the ward and also has responsibility for two resettlement wards on the hospital site. There is also a senior house officer and a registrar who are both part of the MDT team and visit the ward	Fully met

			daily. The staff on the ward advised that they feel they are well supported by the medical team.	
33	6.3.1 (a)	It is recommended that the Trust reviews clinical resources for patients on the ward to ensure that screening takes place with regard to patients' physical health care needs.	Senior trust members advised that this issue has been highlighted by them with the commissioner and to date they have had no response in relation to the availability of a comprehensive screening programme for patients' physical health/primary care needs when on the wards. This recommendation will be restated for a second time	Partially met
34	5.3.1 (a)	It is recommended that the ward manager ensures that care plans in relation to the management of distressed reactions from patients are developed further. These plans should include triggers which may suggest deterioration in behaviour patterns and the proactive strategies in place to manage the situation.	In the three sets of care documentation reviewed by the inspector there was evidence that care plans were linked to positive behaviours support (PBS) plans which detailed the management of distressed reactions from patients. These PBS plans included triggers which may suggest deterioration in a patient's behaviour and the proactive strategies in place to manage this situation.	Fully met

Quality Improvement Plan

Unannounced Inspection

Cranfield ICU, Muckamore Hospital

13 May 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 charge nurse and other members of senior hospital management.

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
Is Care Safe?					
1	5.3.2	It is recommended that the Trust review the mechanism on the door in the seclusion room to ensure that it is set to unlock automatically if the fire alarm is triggered.	1	30 September 2015	The Trust has reviewed the seclusion room door and it would posea health and safety risk to have this door automatically open in the event of a fire alarm. Any patient who requires seclusion is acutely distressed, and will have dedicated staff present at all times outside the seclusion room. Sseclusion is only used for the least and shortest possible period. Staff present when a fire alarm is triggered will assess the most appropriate time and resources required to open the door in a safe manner minimising any potential risk to the patient and those present in the immediate vicinity.
Is Care Effective?					
2	4.3 (m)	It is recommended that the Trust ensures that all staff receive training in relation to capacity to consent to care and treatment to include an understanding of the	2	31 August 2015	Three staff in Cranfield ICU require training in relation to capacity and consent. One of these staff is on long term sick leave and will be booked on to training on their return. The other three have been booked to attend and will have

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
		DHSSPS guidance on decision making and consent for patients who do not have capacity to consent.			completed training by August 15
3	6.3.1 (a)	It is recommended that the Trust reviews the availability of and access to occupational therapy for patients on the ward	2	30 September 2015	Patients in the ward can be referred to Occupational Therapy based on assessed need and agreed by the MD team
Is Care Compassionate?					
4	6.3.1 (a)	It is recommended that the Trust reviews clinical resources for patients on the ward to ensure that screening takes place with regard to patients' physical health care needs.	2	30 September 2015	The Trust has highlighted this gap in service provision to the commissioner. A meeting with the HSCB and the DOHwas held in January 2015. A proposed service development paper will be submitted to thte HSCB by 31st August 2015 and a further meeting is being scheduled at present to disscuss the proposal..

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	Sean Murray
NAME OF CHIEF EXECUTIVE / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Martin Dillon

Inspector assessment of returned QIP		**Yes**	**No**	**Inspector**	**Date**
A.	Quality Improvement Plan response assessed by inspector as acceptable	x		Audrey McLellan	**30/7/15**
B.	Further information requested from provider				