The Regulation and Quality Improvement Authority

RQIA

Mental Health and Learning Disability

Unannounced Inspection

Cranfield ICU, Muckamore Abbey Hospital

Belfast Health & Social Care Trust

25 & 26 September 2014

npm national preventive mechanism

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Contents

1.0 General Information

Ward Name	Cranfield ICU
Trust	Belfast Health & Social Care Trust
Hospital Address	Muckamore Abbey Hospital 1 Abbey Road Muckamore BT41 4SH
Ward Telephone number	028 94662608
Ward Manager	Sean Murray
Email address	sean.murray@belfasttrust.hscni.net
Person in charge on day of inspection	Sean Murray
Category of Care	PICU Learning Disability
Date of last inspection and inspection type	3 June 2014, Patient Experience Interviews
Name of inspector(s)	Audrey Woods; Siobhan Rogan; Frances Gault; Dr Oscar Daly; Professor Nichola Rooney

2.0 Ward profile

Cranfield ICU is a six bedded mixed gender ward on the Muckamore Abbey Hospital site. 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. There were no patients on leave on the day of the inspection

Patients within Cranfield ICU receive input from a multidisciplinary team which incorporates psychiatry; nursing; behavioural support; and social work professionals. A patient advocacy service is also available.

On the days of the inspection the ward environment was calm and welcoming. The ward appeared well maintained, clean and tidy. There was clear signage on entry to the ward and there were written signs and pictures on the internal doors indicating the purpose of each room. Information leaflets were

displayed on the notice board which included information on how to make a complaint and advocacy services. Information was also displayed on who was on duty and what activities were available on each day of the week. There were also individual timetable booklets displayed for each patient on the ward which were in an easy read format.

Each patient had their own bedroom and en-suite which is designed to promote patient dignity and privacy. All patients have a notice board in their rooms to display personalised information of their choice e.g. photographs, activities, hobbies and interests.

Bathrooms were clean, tidy and clutter free. There was an area for visitors to meet with patients in private and visitors also have the option of meeting their relatives in their own room if they choose. The entry and exit door to the ward was locked.

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 inspectors 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 inspectors would like to thank the patients and staff for their cooperation throughout the inspection process.

4.0 Review of action plans/progress

An unannounced inspection of Cranfield ICU was undertaken on 25 & 26 September 2014.

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

The recommendations made following the two previous unannounced inspections on 17 May 2013 and 1 July 2013 were evaluated. The inspectors were pleased to note that 11 of the 19 recommendations had been fully met and compliance had been achieved in the following areas:

- A new pro-forma has been introduced onto the ward to record episodes of seclusion
- All staff have received training in managing challenging behaviours and safeguarding vulnerable adults.
- Capacity assessments have been completed in relation to patients ability to manage their financial affairs
- Staff induction programmes include training for all new staff in vulnerable adult policies and procedures
- Where appropriate staff contact relatives as part of the vulnerable adult process
- The role, function and the frequency of patient forum meetings have been reviewed and advocates are invited to attend
- A procedure is now in place to report and monitor patient items
- A multi-disciplinary team template has been devised which evidences stakeholders present, issues discussed, actions planned and outcomes
- Interventions developed by the multi-disciplinary team have been implemented

However, despite assurances from the Trust, four recommendations had been partially met, three recommendations had not been met. Compliance with one recommendation could not be assessed as part of this inspection.

Six recommendations will require to be restated for a second time and one recommendation will be restated for a third time, in the Quality Improvement Plan (QIP) accompanying this report.

4.2 Review of action plans/progress to address outcomes from the patient experience interview inspection

The recommendations made following the patient experience interview inspection on 3 June 2014 were evaluated. The inspectors were pleased to note that one recommendation had been fully met and compliance had been achieved in the following areas:

- There is no longer patients from another ward attending Cranfield ICU during the day

However, despite assurances from the Trust, one recommendation had been partially met. This recommendation will require to be restated for a second time in the Quality Improvement Plan (QIP) accompanying this report.

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

The recommendation made following the finance inspection on 31 December 2013 was evaluated. The inspectors were pleased to note that this recommendation had been fully met and compliance had been achieved in the following areas:

- All staff now record when they obtain the key to the patients drawers where their money is kept and they record the reason for access to the drawer.

Details of the above findings are included in Appendix 1.

5.0 Inspection Summary

Since the last inspection, inspectors found that progress had been made in some aspects of care and treatment on the ward. Patient forum meetings have been reviewed and are now in place with patients being given the opportunity prior to the meeting to discuss issues regarding the ward.

Staff induction programmes now include training for all new staff in vulnerable adult policies and procedures

A multi-disciplinary team template has been devised which evidences stakeholders present, issues discussed, actions planned and outcomes.

Phased transition approaches have taken place to assist patients in attending day care on the hospital site

Relatives who returned their questionnaires stated their family member had received excellent care on the ward

The ward no longer has a patient from another ward using the Cranfield ICU ward during the day

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.

There was a good relationship between nursing staff and the Behaviour Nurse Therapist, which encouraged a consistent approach to behavioural interventions on the ward.

There was access to Art Therapy. No clinical psychology is currently available, although a locum post has recently been advertised and psychology consultation is available via the learning disability forensic psychology service. The consultant psychiatrist was keen to have the situation remedied so that there could be full involvement of the MDT in care planning and ward rounds.

There was a pleasant and relaxed atmosphere on the ward. Attempts had been made to make the environment welcoming and patients were involved in decorating the space.

There was evidence of visual schedules, which had been developed in collaboration with patients and which were located within their bedrooms. Visual scheduling was also evidenced in practice to encourage a patient to self regulate their smoking behaviour.

Inspectors did not see any evidence that patients' capacity to consent to care and treatment was being monitored and re-evaluated regularly throughout their admission in Cranfield ICU. A recommendation has been made in relation to this

Patients had received medical interventions on the ward and in the community however there was no evidence in the care documentation that patients, who staff indicated did not have capacity to make decisions regarding their care and treatment, had a multidisciplinary best interest decision completed as outlined in the ward self-assessment. A recommendation has been made in relation to this.

There was no evidence in the care plans reviewed by inspectors that patients' human rights had been considered with reference to the Human Rights Articles 8 and 14. A recommendation has been made in relation to this.

Four of the eight staff who completed and returned questionnaires indicated that they had not received training relating to capacity to consent to care and treatment. In addition, inspectors were concerned that staff working on the ward did not appear to be familiar with DHSSPS guidance on decision making and consent for patient who do not have capacity to consent. A recommendation had been made in relation to this.

Easy read information was available for patients which included information about Cranfield ICU ward and the vulnerable adult process. Information was displayed around the ward in easy read format which included information on patient's rights in Muckamore.

Of the four sets of care documentation reviewed by the inspectors, two contained information in the section 'About me'. This section provides patients, carers and relatives an opportunity to provide information about the patient, including likes and dislikes, wishes, wants and preferences which assists in providing a holistic assessment of the patients. A recommendation has been made in relation to this.

There was evidence in the care documentation that the relatives of some patients had attended multi-disciplinary team meetings. Patients were also encouraged to attend these meetings and if they refused, staff stated that they would have a discussion with the patient prior to the meeting. However, this was not consistent throughout the four sets of care documentation reviewed by the inspectors. Inspectors did not see any evidence in the care documentation that patients had been given adequate time and resources to optimise their understanding of the implications of their care and treatment. A recommendation has been made in relation to this.

Inspectors found that care plans were not person centred and did not inform the care and treatment patients were receiving on the ward. Patients, relatives or advocates involvement in the development of or agreement to the interventions within care plans was not evidenced in all files reviewed. A recommendation has been made in relation to this.

Comprehensive risk assessments did not indicate or support the use of some restrictive practices that were in place. Inspectors found that the rationale to support the use of restrictive interventions being implemented included risks that were not recorded in the patient's comprehensive risk assessment or nursing assessment. There was no evidence in the care documentation of the development or implementation of an intervention to reduce the level of restriction using a skills development and recovery based approach. A recommendation has been made in relation to this.

Inspectors noted that incorrect names of patients had been used in one care plan and a care document from another patient who had been discharged was in another patients file. A recommendation has been made in relation to this.

There was information on the ward in easy read format on human rights. There was no evidence in the care documentation that respect for private and family life had been considered when completing assessments and devising associated care interventions. However there was evidence in the patients' continuous nursing notes that patients Article 8 right to respect and family life had been considered.

It was good to note that there was evidence that progress had been made with one patient in relation to the number of times they had required to use the seclusion room. This patient had a number of different behaviour support plans in their care documentation therefore it was difficult to establish which behaviour programme was currently in place for this patient. There was no explanation recorded as to why the episodes of seclusion had significantly reduced over the past number of months. Staff who met with inspectors were able to identify interventions that may have contributed to the reduction in episodes of seclusion required however this was not clearly evaluated. A recommendation has been made in relation to this

Inspectors noted that patients on the ward who attend day care and take part in various ward based activities have a record of this included in their individual daily planner. However this information was not recorded in the

patients care plans or the continuous nursing notes to indicate ongoing monitoring and evaluation of all aspects of care and treatment. A recommendation has been made in relation to this.

Inspectors observed staff engaging with and supporting patients to participate in ward based activities on the days of the inspection. Inspectors noted that interaction between staff and patients was responsive, appropriate and respectful.

There was no evidence of any occupational therapy input on the ward on the days of the inspection. There was no record in the patients care documentation that occupational therapy was available to patients on the ward. Individualised assessments for therapeutic and recreational activities for patients were not available on the days of the inspection. A recommendation has been made in relation to this

There was no evidence in the care documentation reviewed by inspectors that consideration had been given to the impact of restrictive practices on the patients Human Rights articles 5, 8 and 14. Statements had been made in the care documentation reviewed by the inspectors in relation to patient's human rights without a record of specific interventions which would promote the patients human rights. A recommendation has been made in relation to this

It was good to note that easy read versions of The Mental Health (Northern Ireland) Order 1986, The Human Rights Act 1998 and the complaints procedure were available on the ward.

Information in relation to advocacy services and how to access this service was available for patients and relatives. The ward information booklet also contained information and guidance in an easy read format.

Inspectors noted that out of the four sets of care documentation reviewed, two had care plans in place which detailed some of the restrictive practices in place for the patients. Inspectors found that the rationale for the restrictive practices was unclear and did not support the level of restriction. A recommendation has been made in relation this.

Relative feedback obtained though questionnaires indicated that relatives were aware of some of the restrictions in place on the ward. However there was no evidence of patient, relative or advocate involvement in assessment and decisions for the use of restrictive practices. A recommendation has been made in relation to this.

Inspectors reviewed four sets of care documentation and noted patients did not have a nursing discharge care plan completed and there was no record of discharge planning meetings having been held. A recommendation has been made in relation to this.

There was no evidence in the care documentation reviewed of patients' relatives being invited or involved in discharge planning meetings or how information was being shared with patients' relatives/carers. A recommendation has been made in relation to this.

Ongoing work had commenced in relation to a patient who would be moving into the community. It was good to note that staff from the community had commenced working with this patient in the ward to assist in building up a therapeutic relationship with the patient for when they are discharged. A behavioural plan was also in place which the staff in the community were implementing as part of this phased transition into the community. However this substantial piece of work was not recorded as a planned care intervention therefore it was unclear how progression was being monitored and recorded to assist the patients discharge into the community. A recommendation has been made in relation to this.

Out of the four sets of care documentation reviewed by the inspectors there was no evidence of input from occupational therapy or speech and language therapy. A recommendation has been made in relation to this.

Details of the above findings are included in Appendix 2.

On this occasion Cranfield ICU has achieved an overall compliance level of moving towards compliance in relation to the Human Rights inspection theme of "Autonomy".

6.0 Consultation processes

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

Patients	**2**
Ward Staff	**0**
Relatives	**0**
Other Ward Professionals	**2**
Advocates	**0**

Patients

Inspectors spoke to two patients on the ward who both appeared very content and happy in the ward. One patient stated they were looking forward to their discharge into the community and told the inspectors that staff were looking for a new home of them. One patient showed the inspectors their bedroom and they appeared pleased to show inspectors their personal items in their room.

Some of the patients in the ward had limited ability to verbally comment on their care and treatment on the ward. The inspectors undertook direct observations on the ward on the days of the inspection. Patients on the ward presented as relaxed in the ward environment.

Relatives/Carers

The inspection was unannounced. There were no relatives available to speak with inspectors on the days of the inspection.

Ward Staff

Inspectors met with nursing staff on the ward on the on the days of the inspection. Staff appeared to be friendly and approachable and were aware of the individual needs of the patients on the ward and responded appropriately.

Other Ward Professionals

Inspectors spoke to the consultant on the ward and a staff nurse who has recently trained as a behavioural nurse.

Advocates

The inspection was unannounced. There were no advocate's available to speak with inspectors on the days of the inspection

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

Questionnaires issued to	Number issued	Number returned
Ward Staff	20	8
Other Ward Professionals	5	0
Relatives/carers	9	2

Ward Staff

Eight questionnaires were returned by ward staff in advance of the inspection. Information contained within the staff questionnaires demonstrated that seven out of the eight staff were aware of Deprivation of Liberty Safeguards (DOLS) – interim guidance however six out of the eight staff had not received training in the areas of Human Rights and five out of the eight staff had not received training in the area of capacity to consent. All staff stated they were aware of restrictive practices on the ward. Examples of restrictive practices as reported by staff included "locked ward" "detention" "seclusion" and "patients monies secured in a locked drawer." Six of the eight staff members had received training in restrictive practices.

All of the staff who returned a questionnaire stated they had received training on meeting the needs of patients who need support with communication and were aware of alternative methods of communication. Staff indicated that processes were in place to meet patients' individual communication needs. Staff reported that all patients had access to therapeutic and recreational activities.

Other Ward Professionals

No questionnaires were returned from other ward professionals

Relatives/carers

Two relative/carer questionnaires were returned in advance of the inspection. Both relatives stated their family member had received excellent care on the ward. Relatives had no concerns about their relative's ability to consent to their care and treatment and one relative stated a formal capacity to consent assessment had been completed and they had been involved in the assessment. One relative did not answer this question. The two relatives

stated that they had been offered the opportunity to be involved in their relatives care and treatment.

The two relatives recorded that their family member had had an individual assessments completed in relation to therapeutic and recreational activities. One relative indicated that their family member required a communication assessment and they were unsure if this had happened or not. But they stated it "probably has happened". They also stated that alternative means of communication had been provided to meet their relative's needs.

One relative stated that information was available on the ward in relation to the Mental Health (Northern Ireland) Order 1986, how to make a complaint, and the advocacy service. One patient relative stated their relatives had not received any of this information on the ward but stated that they had been told about the advocacy service "a week ago". A recommendation has been made in relation to this.

Both relatives were aware of restrictive practices on the ward, however one relative stated they were not aware of any restrictions in relation to the garden area or enhanced observations.

Specific issues raised by relatives are included in the inspection findings

7.0 Additional matters examined/additional concerns noted

Complaints

Inspectors reviewed complaints received by the ward between 1 April 2013 and 31 March 2014. One complaint had been received which was in relation to staff attitude. All of the complaints were recorded as having been resolved to the satisfaction of the complainant. Inspectors found the ward's complaint procedure to be in accordance with the Trust's policy and procedure. Inspectors noted that information relating to the complaints procedure was available to patients and their carer/relatives.

Inspection Findings – RQIA Psychiatry & Psychology Clinical Professional Advisors

A consultant psychiatrist and consultant psychologist from the Mental Health and Learning Disability team in the Regulation and Quality Improvement Authority participated in this inspection.

The inspectors noted the range of presenting needs of patients on Cranfield ICU. There were patients on the ward who required acute assessment and treatment, and patients who are ready for resettlement into the community and have been on the ward for a number of years. The purpose of the ward is to provide assessment and treatment to patients with a learning disability who

need to be supported in an acute intensive care environment therefore the current mix was not considered appropriate. A recommendation has been made in relation to this.

The multidisciplinary team working with patients on the ward included medical staff, nursing staff, the ward social worker and day care workers. However, there had been no psychology input since the psychologist left in June 2014 and with only very limited input now commencing. There were 1 ½ occupational therapists for the whole hospital, one of whom had been recently appointed. There appeared to be no regular occupational therapy input into the ward. The consultant in charge of the ward was also responsible for the patients on two other wards, totalling 35 inpatients altogether. The consultant psychiatrist was assisted by one senior house officer and, intermittently, one specialist registrar. Recommendations have been made in relation to this.

It was noted that screening patients for physical health care needs was an issue. Inspectors were informed that senior trust representatives were meeting with HSCB to try and obtain resources to address this gap. However management should be considering how they might address this problem in the event of no additional resource being provided. A recommendation has been made in relation to this.

Inspection Findings – RQIA Pharmacy Inspector

A senior inspector from the pharmacy team in the Regulation and Quality Improvement Authority joined inspectors from the Mental Health and Learning Disability team on this inspection.

Management of Pro Re Nata (PRN) medicines

The inspector reviewed the medication kardexes and care notes for four of the six patients on the ward on the day of the inspection. The quality of the detail in the patients care plans in relation to the management of distressed reactions was inconsistent across the ward. There was an inconsistency in relation to recording triggers which may suggest deterioration in behaviour patterns and the strategies in place to try and manage the situation. Staff should ensure that all care plans are further developed. A recommendation has been made in relation this

The medication kardexes reviewed during the inspection evidenced entries in relation to medicines prescribed on a 'PRN' basis for behaviour that challenges. These clearly stated the dose to be administered, and the time frame between the administrations of each medicine. If more than one medicine was prescribed 'prn' there was a clear indication which medicine was to be administered as the 1st line treatment.

The daily notes reviewed by inspectors referred to episodes of behaviour that challenges and the administration of prescribed medicines. However, staff did not consistently document the effect the administration of the medicine had on

the patient's well being. There was evidence that some patients recognise the decline in their well being and request their 'PRN' medication. A recommendation had been made in relation to this

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 the implementation of any recommendations made following the unannounced inspection 17 May 2013

No.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	The inspector will view the proforma used for restrictive practices during patients' time in seclusion	A new proforma has been introduced to record seclusion on the ward. The number of episodes of seclusion for each patient on the ward is collated and reviewed on a weekly basis by the multidisciplinary team and on a monthly basis by the senior management team within the hospital.	**Fully met**
2	The inspector will review staff training records for management of challenging behaviours and protection of vulnerable adults	Inspectors reviewed training records relating to safeguarding vulnerable adults and managing challenged behaviour. Inspectors found that all staff working on the ward had completed up to date MAPA training and training in relation to safeguarding vulnerable adults.	**Fully met**
3	The inspector will review risk assessments and care plans in relation to restrictions on phone, money and cigarettes	Inspectors reviewed for sets of care documentation and noted that restrictive practices were documented within care plans however the restrictions in place were not supported by comprehensive risk assessments and the rationale recorded did not support the level of restriction in place for all patients. This recommendation will be restated for a second time	**Not met** This recommendation has been amended and restated as a new recommendation in the quality improvement plan accompanying this report.
4	The inspector will review that the capacity assessment has been carried out on patients in regard to their competency to manage their own money.	Inspectors found that assessments had been completed in relation to patient's ability to manage their financial affairs.	**Fully met**

Appendix 1

Follow-up on recommendations made following the unannounced inspection on 1 July 2013

No.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	It is recommended that vulnerable adults safeguarding procedure is included in all induction programmes.	Inspectors reviewed the staff induction programme which included training for all new staff in vulnerable adult policies and procedures	**Fully met**
2	It is recommended that action plans following supervision are recorded, agreed and monitored.	Supervision records reviewed by inspectors evidenced that supervision had taken place six monthly for four staff. However supervision for three members of staff was overdue and had not taken place since May 2013. Action plans were not recorded in the supervision records for all staff. This recommendation will be restated for the second time.	**Not met**
3	It is recommended that safeguarding vulnerable adults procedures incorporate informing relatives as part of the process.	Inspectors reviewed records relating to safeguarding vulnerable adults which evidenced that where appropriate, staff had contacted relatives as part of the process	**Fully met**
4	It is recommended that the signing off and review of risk assessments are monitored.	Inspectors' reviewed four sets of patient notes. Inspectors found that comprehensive risk assessments had been completed and were available for two out of the four patients. Inspectors were informed that the comprehensive risk assessments had been completed for the other two patients however they were not available on the day of the inspection. The two assessments that were available had been signed off and were reviewed however this review was six monthly. This recommendation will be restated for the second time.	**Partially met**

5	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 October 2010.	Records indicated that 16 of the 21 staff working on the ward at the time of the inspection had completed training on Human Rights and Deprivation of Liberty Safeguards (DOLS) – Interim Guidance, five staff were still to receive this training**.** This recommendation will be restated for the second time	**Partially met**
6	It is recommended that Deprivation of Liberty Safeguards (DOLS) – Interim Guidance, as outlined by the DHSSPSNI in October 2010, is implemented within Cranfield ICU.	All patients in Cranfield ICU were detained under the Mental Health (Northern Ireland) 1986. Inspectors reviewed four sets of notes which all indicated that restrictive practices were in place. However, there was no record of actions to be taken as outlined in the Deprivation of Liberty Safeguards (DOLS) – Interim Guidance within the care documentation reviewed by the inspectors. There was a 'blanket restriction' on the ward as it was a locked ward whereby patients had to go through a number of doors before they could leave the building. However there was no record in the care documentation to explain the rationale to support this practice. Inspectors found that the rationale for some restrictive practices was unclear and did not support the level of restriction. For example one restrictive practice care plan stated that "the environment was deemed most suitable to manage the risks that ….. poses towards ……. and others" , however there was no documentation detailing what these risks were. Out of the four sets of care documentation reviewed by the inspectors there was only two comprehensive risk assessments completed for these patients. The two comprehensive risk assessments that were in place did not indicate or support the use of some restrictive practices that were in place. Inspectors found that the rationale to support the use of restrictive interventions being implemented included risks that were not recorded in the patient's comprehensive risk assessment. For example one patient's care documentation in relation to	**Not met**

		restrictive practice indicated that this practice was necessary to avoid fire setting however this patient had no history of fire setting and it was not identified as a risk on the comprehensive risk assessment. Inspectors noted that incorrect names of patients had been used in one care plan and a care document from another patient who had been discharged was in another patients file This recommendation will be restated for the second time.	
7	It is recommended that the role and function of patient forum meetings are clarified and that the advocate attends to enhance transparency.	Records were available of patient forum meetings which had been held by staff on the ward. The role and function of the meetings were explained to the patients prior to the meeting commencing. A new format had been introduced in May 2014 which gave the patients an opportunity to record their views of the ward prior to the meetings. The advocate was invited to the meetings however to date the meetings had not been attended by advocates.	**Fully met**
8	It is recommended that the frequency of patient forum meetings is reviewed. Consideration should be given to the expected length of patient stay on the ward as part of this review.	Patient forum meetings are held once every three months. Views of patients are sought prior to the meeting and this was recorded in a pictorial format. In Cranfield ward there was a mixture of acute assessment and long stay patients on the ward.	**Fully met**
9	It is recommended that a procedure for reporting and monitoring patient items that have gone missing is developed, implemented and communicated to patients.	All patients' items are recorded on arrived to the ward and this record is stored in the patients file. If more items are brought in for the patients this is also recorded and stored in the patients file	**Fully met**
10	It is requested that the impact the of the issues relating to the mixed gender ward is monitored and assessed over the six month period until March 2013 and a report furnished to RQIA.	A report in relation to the impact of mixed gender on the ward was forwarded to RQIA	**Fully met**

11	It is recommended that the multidisciplinary team template which fully evidences stakeholders present issues discussed, actions planned and outcome is finalised and implemented.	Inspectors reviewed four sets of care documentation and there was evidence that a new template had been implemented on the ward which recorded stakeholders present, issues discussed, actions planned and outcomes.	**Fully Met**
12	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.	Inspectors reviewed four sets of care documentation. Two out of the four sets of care documentation did not have a comprehensive risk assessment or care plans/interventions in place to address assessed needs. Inspectors found that assessments had been completed and needs identified for two patients without follow up care interventions in place. Restrictive practices were in place however the care documentation did not detail the rationale for the use of the restrictive interventions in place. It was unclear which care plan or behaviour support plan was current to the patients care and treatment as there were a number of plans available in the care documentation reviewed This recommendation will be restated for a second time.	**Partially met**
13	It is recommended that care documentation is updated to ensure inaccuracies relating to RQIA recommendations are corrected.	This recommendation was made in relation to care documentation for one patient who was no longer a patient on the ward therefore this recommendation was not assessed.	**Not assessed**
14	It is recommended that information and correspondence relating to patient care and treatment is recorded clearly in the patient's care documentation to ensure accuracy.	Inspectors found evidence that care plans were completed for two out of the four patients. Records showed that assessments had been completed for two patients however follow up care interventions/plans had not been developed to address needs identified. Continuous notes did not evidence that the care and treatment was monitored and reviewed by staff on the ward. This recommendation will be restated for a second time.	**Partially met**
15	It is recommended that interventions developed by the multidisciplinary team are implemented as agreed.	There was evidence in the care documentation reviewed and practice observed on the days of the inspection that interventions agreed by the multi-disciplinary team had been implemented	**Fully met**

Appendix 1

Follow-up on recommendations made following the patient experience interview inspection on 3 June 2014

No.	Reference.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	5.3.1.f	It is recommended that the ward manager ensures the staff assistance emergency alarm within the Cranfield unit is reviewed.	Inspectors were advised that ongoing work is taking place in relation to the alarm system. This has proven difficult to implement due to the complex system in place This recommendation will be restated for a second time.	**Partially met**
2	5.3.1 a	It is recommended that ward manager ensures the arrangement in place for patients from another ward who are using the Cranfield ICU during the day is kept under review. This review needs to consider the impact this practice has on the other patients and records what other alternatives have been considered and discounted.	Inspectors were advised that due to the impact on patients in ICU, the practice of patients from other wards using ICU is only used as a last resort. However due to the difficulties and delays in discharging patients from hospital, there are occasions when patients from other wards need to be cared for in ICU. There were no patients from any other ward staying in Cranfield ICU during the day on the days of the inspection.	**Fully met**

Appendix 1

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.	Records reviewed showed that all staff who obtain keys to the drawers where patient‘s money is stored including the reason for access was recorded appropriately and signed off by staff members.	**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	N/A	**N/A**	**N/A**

Quality Improvement Plan

Unannounced Inspection

Cranfield ICU, Muckamore Abbey Hospital

25 & 26 September 2014

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

The specific actions set out in the Quality Improvement Plan were discussed with the ward manger and senior members of the Trust on the days of the inspection visit.

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

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
1	4.3. (i)	It is recommended that the ward manager ensures that action plans following supervision are recorded, agreed and monitored	2	31 December 2014	In response to this recommendation an updated template is in use. Action plans following supervision are recorded, agreed and monitored by the ward manager.
2	5.3.1 (a)	It is recommended that the ward manager ensures the signing off and review of risk assessments are monitored	2	Immediate and ongoing	The ward manager will ensure that the ongoing monthly audit of risk assessments monitors the signing off and review of risk assessments..
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 October 2010.	2	31 January 2015	2 staff have been booked to attend training on 4th December and 4 have been booked for 19th December 2014. This will complete the current staffs training on dols.
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.	3	Immediate and ongoing	Deprivation of Liberty Safeguards (DOLS) – Interim Guidance, as outlined by the DHSSPSNI in October 2010, has been implemented in Cranfield ICU. In response to the recommendation, care plans in relation to the use of restrictive practice in the ward have been reviewed. All patients are individually assessed in relation to risk and a clear

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
					rationale documented if restrictive practice is required.
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.	2	Immediate and ongoing	The ward manager carries out monthly internal audits within the ward to monitor care documentation. The audit tool used has been reviewed to reflect this recommendation. The independent audit tool has also been reviewed and updated.an independent audit will be completed by December.. Learning from both these audits is shared with all staff in the ward. Both audits monitor 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.
6	5.3.1 (f)	It is recommended that information and correspondence relating to patient care and treatment is recorded clearly in the patient's care documentation to ensure accuracy	2	Immediate and ongoing	The ward manager carries out monthly internal audits within the ward to monitor care documentation. The audit tool used has been reviewed to reflect this recommendation. The external audit tool has also been reviewed and updated. An independent audit has been arranged

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
					(The auditors are members of the care plan governance group - the Resource Nurse and a ward manager from another ward). Learning from both these audits is shared with all staff in the ward. Both audits monitor information and correspondence relating to patient care and treatment is recorded clearly in the patient's care documentation to ensure accuracy
7	5.3.1.(f)	It is recommended that the ward manager ensures the staff assistance emergency alarm within the Cranfield unit is reviewed.	2	31 March 2015	A meeting has been held with the Trust Estates Operations Team and the Contractor responsible for the installation of the Guardian System – a full survey has been completed and it has been established what the issues are. Remedial works will be completed by Dec 14.
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	2	31 December 2014	In response to this recommendation care plans in relation to the use of restrictive practice in the ward have all been reviewed and The rationale addresses necessity and proportionality. The ward manager will monitor this through the care plan

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
		proportionality.			audit.
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.	1	Immediate and ongoing	Patient consent to care and treatment is assessed and recorded in their assessment of needs. This includes how the treatment or care is and will be delivered and how the patient demonstrates consent. If a patient does not consent to a particular activity this is also recorded in the assessment. Consent to care and treatment is reassessed and reviewed as part of the on-going care plan review. The ward manager will ensure this through the updated care plan audit.
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 Guide to Consent for Examination,	1	Immediate and ongoing	It is assumed that all patients have capacity Patient consent to care and treatment is assessed and recorded in their assessment of needs. If a patient has been assessed as not having the capacity to consent to care and treatment a record is completed in the patients assessment of needs as to how the treatment or care is and will be delivered in the patients best interests as per

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
		Treatment or Care			DHSSPS guidance The assessment of capacity to make non-routine or more serious decisions are discussed with the MDT and recorded, in consultation with relevant others i.e. the patient and relatives/carers and advocates, and considering the persons best interest. The ward manager will monitor this through the updated care plan audit.
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	1	Immediate and ongoing	In response to this recommendation , care plans in relation to the use of restrictive practice in the ward have been reviewed, consideration has been given to the impact a restrictive practice may have on patients Human rights and specifically to articles 5, 8 and 14. A plan of care is developed based on assessed need. The ward manager ensures this through the updated care plan audit
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	1	31 February 2015	2 staff have been booked to attend training on 4th December and 4 have been booked for 19th December 2014

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
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 making and consent for patients who do not have capacity to consent.	1	31 December 2014	3 staff are booked to attend training on 17th November 2014. 2 staff are booked to attend training on 17th February 2015.
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	1	Immediate and ongoing	In response to this recommendation, the internal audit for auditing care plans in the ward has been reviewed and updated. The audit assists the ward manager in ensuring information regarding the patients/relatives attendance and input in multi-disciplinary meetings is recorded on the MDT template
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.	1	31 December 2014	In response to this recommendation, the internal audit for auditing care plans in the ward has been reviewed and updated. The audit assists the ward manager in ensuring all patients have an up to date comprehensive assessment in place. If appropriate, the assessment will have been compiled in partnership with the patient and

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
					family/carer.
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. .	1	31 December 2014	In response to this recommendation, the internal audit for auditing care plans in the ward has been reviewed and updated. The audit assists the ward manager in ensuring care plans have been reviewed and updated to demonstrate a more person centred approach. Plans of care have been developed appropriately. The ward manager carries a monthly audit of care plans to ensure standards are met.
17	5.3.1 (a)	It is recommended that the ward manager ensures that all patients are screened to see if they require 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	1	31 December 2014	On admission, patients are screened (using the brief screening tool) to ascertain if a comprehensive risk assessment is required, This is a MDT decision, and if a CRA is not required a clear rationale is documented on the brief screening tool. The need for use of a restrictive practice is assessed through the nursing care plan and the CRA (when a CRA is required). Intervention to reduce the use of restrictive practice is discussed by the MDT meeting and recorded in the care plan. The ward manager carries a monthly

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
		developing an intervention to reduce this level of restriction using a skills development and recovery based approach.			audit of care plans to ensure these standards are met.
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	1	31 December 2014	In response to this recommendation and through the audit of care plans, the ward manager ensures patients and where appropriate their relatives/carers have the opportunity to contribute to the comprehensive risk assessment and sign the documentation when appropriate
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	1	Immediate and ongoing	The ward manager carries out monthly internal audits within the ward to monitor care documentation. The audit tool used has been reviewed to reflect this recommendation. The independent audit tool has also been reviewed and

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
		stored in the correct patients file			updated. An independent audit has been arranged. (The auditors are members of the care plan governance group - the Resource Nurse and a ward manager from another ward). Learning from both these audits is shared with all staff in the ward. The audits monitor clear documentation of patients names and file numbers on all documentation in the care plan.
20	5.3.1 (a)	It is recommended that the ward manger 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.	1	Immediate and ongoing	The ward manager carries out monthly internal audits within the ward to monitor care documentation. The audit tool used has been reviewed to reflect this recommendation. The independent audit tool has also been reviewed and updated. An external audit has been arranged (The auditors are members of the care plan governance group - the Resource Nurse and a ward manager from another ward). Learning from both these audits is shared with all staff in the ward. The audits monitor interventions to address patients behavioural presentation are current and that the implementation of such interventions is evaluated and records are in place to evidence

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
					progress.
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	1	31 December 2014	The Psychology post is in the process of recruitment. Previous recruitment processes did not attract sufficient interest and national adverts are being pursued
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.	1	Immediate and ongoing	The ward manager carries out monthly internal audits within the ward to monitor care documentation. The audit tool used has been reviewed to reflect this recommendation. The external audit tool has also been reviewed and updated. An independent audit has been arranged (The auditors are members of the care plan governance group - the Resource Nurse and a ward manager from another ward). Learning from both these audits is shared with all staff in the ward. Both audits monitor and evaluate patients access to and participation in therapeutic activities
23	5.3.1 (a)	It is recommended that the ward manager ensures that patients have individualised assessments	1	31 December	The ward manager carries out monthly internal audits within the ward to monitor care documentation. The audit tool used has been

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
		completed for aspects of care including therapeutic and recreational activities		2014	reviewed to reflect this recommendation. The independent l audit tool has also been reviewed and updated. An external audit has been arranged. (The auditors are members of the care plan governance group - the Resource Nurse and a ward manager from another ward). Learning from both these audits is shared with all staff in the ward. Both audits monitor that patients have individualised assessments completed for therapeutic and recreational activities
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.	2	31 December 2014	In response to this recommendation care plans in relation to the use of restrictive practice in the ward have been reviewed. All patients are individually assessed in relation to risk and a clear rationale indicated. The rationale addresses necessity and proportionality. The ward manager ensures this through the care plan audit.
25	5.3.3 (b)	It is recommended that the ward manager ensures that patients, relatives and were appropriate advocates are given the	1	Immediate and ongoing	The ward manager carries out monthly internal audits within the ward to monitor care documentation. The audit tool used has been reviewed to reflect this recommendation. The

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
		opportunity to be involved in assessments and decisions with regard to the use of restrictive practices			independent audit tool has also been reviewed and updated. An independent audit has been arranged. (The auditors are members of the care plan governance group - the Resource Nurse and a ward manager from another ward). Learning from both these audits is shared with all staff in the ward. Patients, relatives and where appropriate advocates are given the opportunity to be involved in assessments and decisions with regard to the use of restrictive practices – this is recorded in the patients care plan.
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.	1	Immediate and ongoing	In response to this recommendation care plans in relation to discharge planning have been reviewed. Once a patient has been identified as being ready for discharge, a plan of care is developed and reviewed as necessary, detailing actions relevant to their discharge. Progress towards these interventions is evaluated in the progress evaluation. The ward manager carries a monthly audit of care plans to ensure this standards is met
27	8.3 (i)	It is recommended that the ward	1	Immediate	Relatives/carers are invited to and are involved in

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
		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.		and ongoing	discharge planning meetings where appropriate. If they are unable to attend this is recorded. The discharge plan includes how information is shared with the patient and carers if they have been unable to attend the meeting. The outcomes of the meetings also identify who is responsible for providing feedback to the patient and the relative/carer. The ward manager carries a monthly audit of care plans to ensure this standards is met
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.	1	31 December 2014	The Trust is currently reviewing the behaviour strategies used within the unit in conjunction with behavioural staff and psychology
29	6.3.2 (a)	It is recommended that the ward manager ensures that all patients and relatives/carer are aware do the advocacy service on the ward.	1	Immediate and ongoing	Posters relating to the advocacy service are in place on the ward and at reception. Patients/ relatives are given a welcome pack on admission to hospital, the admission pack includes details about advocacy services

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
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.	1	31 March 2015	Patients in the ward can be referred to Occupational Therapy and Speech & Language Therapy based on assessed need
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.	1	31 March 2015	The Trust reviews the current mix in ICU patients with the MDT regularly to ensure that the ward remains the most appropriate available setting for the patients pending their discharge to a community placement/setting.

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
32	6.3.1 (a)	It is recommended that the Trust reviews the medical staffing level availability for the ward.	1	31 March 2015	The Trust will review medical staffing levels and benchmark this against National and Regional levels
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	1	31 March 2015	The Trust has highlighted this gap in service provision to the commissioner. A meeting with the HSCB and the DOH is being planned/scheduled at present
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.	1	31 December 2014	In response to this recommendation, the patients behaviour plans / incentive plans have been reviewed in conjunction with behaviour services. Plans have been updated to include clear triggers and proactive strategies to manage these situations.

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				**Inspector**	**Date**
		Yes	**No**		
A.	Quality Improvement Plan response assessed by inspector as acceptable	x		Rosaline Kelly	**03/12/14**
B.	Further information requested from provider				

Ward Self-Assessment

Statement 1: Capacity & Consent • **Patients' capacity to consent to care and treatment is monitored and re-evaluated regularly throughout admission to hospital.** • **Patients are allowed adequate time and resources to optimise their understanding of the implications of their care and treatment.** • **Where a patient has been assessed as not having the capacity to make a decision there are robust arrangements in place in relation to decision making processes that are managed in accordance with DHSSPS guidance.** • **Patients' Article 8 rights to respect for private and family life & Article 14 right to be free from discrimination have been considered**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
When a patient has been assessed as not having the capacity to consent to care and treatment a record is completed in the patients assessment of needs as to how the treatment or care is and will be delivered in the patients best interests as per DHSSPS guidance However, the assessment of capacity to make non-routine or more serious decisions are discussed with the MDT and recorded using the best interest check list and decision record, in consultation with relevant others i.e. the patient and relatives/carers and advocates, and considering the persons best interest. The best interest checklist form can be used either if people are consulted individually or as part of a best interest case conference. There are no patients in Cranfield ICU at present, who have required this process. The section 'About me' provides patient/carer/relative an opportunity to provide information about the patient, including likes/dislikes, wishes/wants and preferences - this section can be taken away for completion in the persons own time. A welcome pack is available on the ward and shared with new admissions and their relatives	Moving towards compliance

Easy read documentation available for patients and families. – i.e. consent, human rights, MHO Relatives are encouraged to be actively involved through open visiting, regular phone calls and invites to MDT meetings. Patients are encouraged to attend the MDT meetings and can request to meet with members of the MD team on other occasions When appropriate visits by patients to the family home are encouraged and facilitated Patients have their own bedrooms and ensuite bathroom. A visitors room is provided to facilitate privacy Care plans are person centred and address family involvement Privacy and dignity is addressed through the patients care plan Human Rights Act is available in the ward, all staff are aware of Article 8 and article 14, both are considered in the patients care plan Human rights awareness training is available for staff through TAS Patients' Finances and Private Property – Policy for Inpatients within Mental Health and Learning Disability Hospitals available in the ward	
Inspection Findings: FOR RQIA INSPECTORS USE Only	
Inspectors reviewed four sets of care documentation and found that there was no evidence that capacity to consent assessments had been undertaken for any of the patients on the ward even though staff felt that some of these patients would have lacked capacity to make decision regarding their care and treatment. Inspectors did not see any evidence that patients' capacity to consent to care and treatment was being monitored and re-evaluated regularly throughout their admission in Cranfield ICU. A recommendation has been made in relation to this Patients had received medical interventions on the ward and in the community however there was no evidence in the care documentation that patients, who staff indicated did not have capacity to make decisions regarding their care and treatment had had a multidisciplinary best interest check list and decision record completed as outlined in the ward self-assessment. A recommendation has been made in relation to this.	Not compliant

There was no evidence in the care plans reviewed by inspectors that patients' human rights had been considered with reference to the Human Rights Articles 8 and 14. A recommendation has been made in relation to this. Three of the eight staff who completed and returned questionnaires indicated that they had not received training relating to Human Rights. A recommendation has been made in relation to this. Four of the eight staff who completed and returned questionnaires indicated that they had not received training relating to capacity to consent to care and treatment. In addition, inspectors were concerned that staff working on the ward did not appear to be familiar with DHSSPS guidance on decision making and consent for patient who do not have capacity to consent. A recommendation had been made in relation to this. Easy read information was available for patients which included information about Cranfield ICU ward and the vulnerable adult process. Information was displayed around the ward in easy read format which included information on patient's rights in Muckamore. Of the four sets of care documentation reviewed by the inspectors, two contained information in the section 'About me'. This section provides patients, carers and relatives an opportunity to provide information about the patient, including likes and dislikes, wishes, wants and preferences which assists in providing a holistic assessment of the patients. A recommendation has been made in relation to this. There was evidence in the care documentation that the relatives of patients had attended multi-disciplinary team meetings. Patients were also encouraged to attend these meetings and if they refused, staff stated that they would have a discussion with the patient prior to the meeting. There was evidence in some of the care documentation that the patients named nurse had a meeting with the patients prior to the ward round so they could give their input to the meeting. There was also a section on the multi-disciplinary template for the patient's views to be recorded. However, this was not consistent throughout the four sets of care documentation reviewed by the inspectors. Inspectors did not see any evidence in the care documentation that patients had been given adequate time and resources to optimise their understanding of the implications of their care and treatment. A recommendation has been made in relation to this.	

Ward Self-Assessment

Statement 2: Individualised assessment and management of need and risk • **Patients and/or their representatives are involved in holistic needs assessment and in development of related individualised, person-centred care plans and risk management plans** • **Patients with communication needs have their communication needs assessed and there are appropriate arrangements in place to promote the patient's ability to meaningfully engage in the assessment of their needs, planning and agreeing care and treatment plans and in the review of their needs and services.** • **Assessment of need is a continuous process and plans are revised regularly with the involvement of the patient and/or their representative and in accordance with any changes to assessed needs.** • **Patients' Article 8 rights to respect for private and family life have been considered.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
All patients have a person centred care plan, which includes a holistic assessment and plans of care to manage identified risk. Care plans are reviewed when there is a change in risk / increase in incidents and at a minimum of 6 monthly. Patients and/or their representative are involved in this process. A risk screening tool is completed and if deemed necessary by the MDT, patients will have a comprehensive risk assessment started. The CRA is reviewed when there is a change in risk and at a minimum of 6 monthly Patients/carers and relatives are involved in patient care and treatment through the nursing care plan, the care plan is signed on completion and when reviewed, if patients or carers/relatives do not want to or are unable to sign – this is indicated Patients who have an assessed communication need have communication passports / communication place mats Patients are referred to Speech & Language therapy when required	Substantially compliant

The Human Rights Act is available in the ward, all staff are aware of Article 8 and Article 14, both are considered in the patients care plan A guide to The Human Rights Act is available in easy read	
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
Inspectors reviewed care documentation relating to four patients. There was evidence in the care documentation that multi-disciplinary meetings were held and patients and their families were given the opportunity to attend these meetings and their views were record on a new template that had recently been introduced to the ward. Out of the four sets of care documentation reviewed by inspectors', two sets had an assessment in place and a care plan following this assessment. However two sets of care documentation had an assessment completed and needs identified however care interventions/plans had not been developed to address identified assessed needs. Of the two sets of care documentation that did contain a care plan there was a record of the patients care and treatment in relation to restrictive practices that were in place however the rationale for the restriction was not clearly defined. Inspectors found that care plans were not person centred and did not inform the care and treatment patients were receiving on the ward. Patients, relatives or advocates involvement in the development of or agreement to the interventions within care plans was not evidenced in some files reviewed. A recommendation has been made in relation to this. Out of the four sets of care documentation reviewed by the inspectors four patients had a risk screening tool completed which indicated that they needed to have a comprehensive risk assessment in place. However there was no evidence in the care documentation of two of the patients that a comprehensive risk assessment had been completed. The two comprehensive risk assessments that were in place did not indicate or support the use of some restrictive practices that were in place. Inspectors found that the rationale to support the use of restrictive interventions being implemented included risks that were not recorded in the patient's comprehensive risk assessment. For example one patient's care documentation in relation to restrictive practice indicated that this practice was necessary to avoid fire setting however this patient had no history of fire setting and it was not identified as a risk on the comprehensive risk assessment. Another care record in relation to restrictive practice indicated that a patient was in hospital because there was no community placement available however this patient was not deemed to be medically fit for discharge. The care documentation for another patient stated that the current environment was the most suitable to manage the risks that the patient posed towards themselves and others but there was no record or details of the risks as the comprehensive risk assessment was not available. The care documentation reviewed did not support the restrictive practices in place or outline the basis on which decisions had been taken. There was no evidence	Moving towards compliance

in the care documentation of the development or implementation of an intervention to reduce this level of restriction using a skills development and recovery based approach. Inspectors reviewed a behavioural programme that was in place for one patient which outlined a contract in relation to the access to cigarettes. It was good to note that the patient had signed up and agreed to this contract however the care plan for this patient outlined different interventions in relation to access to cigarettes which contradicted the behavioural contract in place. Recommendations have been made in relation to this One of the comprehensive risk assessments that was reviewed by the inspectors had been completed in February 2014 however there was no evidence that it had been discussed with the patients' family until September 2014 even though records indicated that the family visited the ward twice a week to see the patient. A recommendation has been made in relation to this. Inspectors noted that incorrect names of patients had been used in one care plan and a care document from another patient who had been discharged was in another patients file. A recommendation has been made in relation to this. There was information on the ward in easy read format on human rights. There was no evidence in the care documentation that respect for private and family life had been considered when completing assessments and devising associated care interventions. However there was evidence in the patients' continuous nursing notes that patients Article 8 right to respect and family life have been considered. It was good to note that there was evidence that progress had been made with one patient in relation to the number of times they had required to use the seclusion room. This patient had a number of different behavioural support plans in their care documentation therefore it was difficult to establish which behaviour programme was currently in place for this patient. There was no explanation recorded as to why the episodes of seclusion had significantly reduced over the past number of months. Staff who met with inspectors were able to identify interventions that may have contributed to the reduction in episodes of seclusion required however this was not clearly evaluated. A recommendation has been made in relation to this Patients on the ward have had no access to clinical psychology input since June 2014. A recommendation has been made in relation to this	

Ward Self-Assessment	
Statement 3: Therapeutic & recreational activity • **Patients have the opportunity to be involved in agreeing to and participating in therapeutic and recreational activity programmes relevant to their identified needs. This includes access to off the ward activities.** • **Patients' Article 8 rights to respect for private and family life have been considered.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
Therapeutic and recreational activity is individually assessed through the patients care plan All patients have individualised activity timetables Patients attend day-care on a sessional basis – off the ward. If assessed as a need patients can avail of in reach day-care Patients participate in therapeutic activities on the ward, these include foot spas, table top activities, art work, music therapy, aromatherapy and hair and beauty A programme of available activities is on display - this includes recreational and therapeutic activities on and off the ward The Human Rights Act is available in the ward, all staff are aware of and consider Article 8 through the patients care plan A guide to The Human Rights Act is available in easy read	Substantially compliant
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
Inspectors noted that patients on the ward who attend day care and take part in various ward based activities have a record of this included in their individual daily planner. However this information was not recorded in the patients care plans or the continuous nursing notes to indicate ongoing monitoring and evaluation of all aspects of care and treatment. A recommendation has been made in relation to this.	Moving towards compliance

Inspectors observed staff engaging with and supporting patients to participate in ward based activities on the days of the inspection. Inspectors noted that interaction between staff and patients was responsive, appropriate and respectful. The ward had an activity room which patients could use to undertake ward activities which included; art therapy, music sessions and cookery sessions. The main ward area displayed art which the patients had been involved in completing. There was no evidence of any occupational therapy input on the ward on the days of the inspection. There was no record in the patients care documentation that occupational therapy was available to patients on the ward. Individualised assessments for therapeutic and recreational activities for patients were not available on the days of the inspection. A recommendation has been made in relation to this There was evidence in the nursing notes that patients article 8 rights to respect for private and family life had been considered. Relatives were encouraged to attend meetings and visiting hours were flexible on the ward for relatives who had to travel long distances.	

Ward Self-Assessment	
Statement 4: Information about rights • **Patients have been informed about their rights in a format suitable to their individual needs and access to the communication method of his/her choice. This includes the right to refuse care and treatment, information in relation to detention processes, information about the Mental Health Review Tribunal, referral to the Mental Health Review Tribunal, making a complaint, and access to independent advocacy services.** • **Patients' Article 5 rights to liberty and security of person, Article 8 rights to respect for private and family life and Article 14 right to be free from discrimination have been considered.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
Easy read leaflets and documents are available for patients and for use by staff / family / advocates The patients charter is available in the ward for patients and relatives - easy read An explanation of the MHO is available in the ward A guide to The Human Rights Act is available in easy read Easy read leaflets are available re levels of observation Easy read booklet – 'You, Muckamore Abbey Hospital and the Law' is available Patients' rights are addressed through the patients care plan The Human Rights Act is available in the ward, all staff are aware of and consider Articles 5, 8 and 14 through the patients care plan	Working towards compliance
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
There was no evidence in the care documentation reviewed by inspectors that consideration had been given to the impact of restrictive practices on the patients Human Rights articles 5, 8 and 14. Statements had been	Moving towards compliance

made in the care documentation reviewed by the inspectors in relation to patient's human rights without a record of specific interventions which would promote the patients human rights. A recommendation has been made in relation to this Easy read versions of The Mental Health (Northern Ireland) Order 1986, The Human Rights Act 1998 and the complaints procedure were available on the ward. Information in relation to advocacy services and how to access this service was available for patients and relatives. The ward information booklet also contained information and guidance in an easy read format. Two relatives who had returned their questionnaires stated that they knew how to access advocacy service on the ward. However one of the relatives stated that they had only been informed about the advocacy service 'a week ago'. A recommendation has been made in relation to this	

Ward Self-Assessment	
Statement 5: Restriction and Deprivation of Liberty • **Patients do not experience "blanket" restrictions or deprivation of liberty.** • **Any use of restrictive practice is individually assessed with a clearly recorded rationale for the use of and level of restriction.** • **Any restrictive practice is used as a last resort, proportionate to the level of assessed risk and is the least restrictive measure required to keep patients and/or others safe.** • **Any use of restrictive practice and the need for and appropriateness of the restriction is regularly reviewed.** • **Patients' Article 3 rights to be free from torture, inhuman or degrading treatment or punishment, Article 5 rights to liberty and security of person, Article 8 rights to respect for private & family life and Article 14 right to be free from discrimination have been considered.**	**COMPLIANCE LEVEL**
Patients have a person centred care plan. Patients needs are individually assessed and if restrictive practice is required, a clear recorded rationale for its use is documented. Use of restrictive practice is agreed by the MDT and reviewed regularly with a view to reducing the restriction – patients, relatives, carers and advocates are encouraged to partake in the review The Human Rights Act is available in the ward, all staff are aware of and consider Articles 3, 5, 8 and 14 through the patients care plan A guide to The Human Rights Act is available in easy read A deprivation of liberties easy read leaflet is available in the ward	Substantially compliant
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
Inspectors noted that out of the four sets of care documentation reviewed only two had care plans in place which detailed some of the restrictive practices in place for the patients. Inspectors found that the rationale for	Not compliant

the restrictive practices was unclear and did not support the level of restriction. For example, one restrictive practice care plan stated the environment was deemed the most suitable for the patient as they posed a risk towards themselves and others. There was no detail of the specific risks this patient posed documented in the care notes. A recommendation has been made in relation this. There was no specific reference throughout the care documentation reviewed on the potential impact of restrictive practices on the patients Articles 3, 5, 8 and 14 Human Rights. Relative feedback obtained though questionnaires indicated that relatives were aware of some of the restrictions in place on the ward. However there was no evidence of patient, relative or advocate involvement in assessment and decisions for the use of restrictive practices. A recommendation has been made in relation to this.	

Ward Self-Assessment	
Statement 6: Discharge planning • **Patients and/or their representatives are involved in discharge planning at the earliest opportunity.** • **Patients are discharged home with appropriate support or to an appropriate community setting within seven days of the patient being assessed as medically fit for discharge.** • **Delayed discharges are reported to the Health and Social Care Board.** • **Patients' Article 8 rights to respect for private and family life have been considered.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
Weekly MDT meetings take place in the ward - discharge planning is considered if the individual is being prepared for discharge. Care managers on occasion attend these meetings and discharge progress meetings if these are applicable. The care manager communicates to the relatives following the meetings. Relatives and advocates are invited to and may attend these meetings. A record of attendance or non-attendance is included in the minutes of the meeting. Delayed discharges are reported to the H&SCB The Human Rights Act is available in the ward, all staff are aware of and consider Article 8 through the patients care plan.	Substantially compliant
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
The ward manager informed inspectors that three out of the six patients in the ward were medically fit for discharge therefore three patients on the ward were delayed in their discharge from hospital. Inspectors reviewed four sets of care documentation and noted patients did not have a nursing discharge care plan completed and there was no record of discharge planning meetings having been held. A recommendation has been made in relation to this. Two of the relatives who returned their questionnaires to RQIA stated that they had not been involved in their relative's discharge planning and were unaware of a discharge plan for their relative. There was no evidence in the care documentation reviewed of patients' relatives being invited or involved in discharge planning meetings	Moving towards compliance

or how information was being shared with patients' relatives/carers. A recommendation has been made in relation to this. Inspectors were informed by the ward manager that ongoing work had commenced in relation to a patient who would be moving into the community. It was good to note that staff from the community had commenced working with this patient in the ward to assist in building up a therapeutic relationship with the patient for when they are discharged. A behavioural plan was also in place which the staff in the community were implementing as part of this phased transition into the community. However this substantial piece of work was not recorded in the care intervention therefore it was unclear how progression was being monitored and recorded to assist the patients discharge into the community. A recommendation has been made in relation to this. Out of the four sets of care documentation reviewed by the inspectors there was no evidence of input from occupational therapy or speech and language therapy. A recommendation has been made in relation to this.	

Ward Manager's overall assessment of the ward's compliance level against the statements assessed	**COMPLIANCE LEVEL**
	Substantially Compliant

Inspector's overall assessment of the ward's compliance level against the statements assessed	**COMPLIANCE LEVEL**
	Moving towards compliant

SUPPLEMENTARY INFORMATION

For information or incidents within the last 12 months, this is interpreted as being from the date of the inspection.

Within the last 12 months, please confirm the number of Under 18 admissions to the ward and the age, gender and length of stay for each placement.							
Admission number	Age	Gender	Length of Stay (days)	Admission number	Age	Gender	Length of Stay (days)
1				8			
2				9			
3				10			
4				11			
5				12			
6				13			
7				14			

Within the last 12 months, please confirm the number of investigations undertaken on the ward and their outcomes.			
Adult Protection Investigations		**Child Protection Investigations**	
Substantiated Allegations	37	Substantiated Allegations	
Unsubstantiated Allegations	2	Unsubstantiated Allegations	
On-going Allegations		On-going Allegations	
Total	39	Total	

Please confirm the names of the following contacts for safeguarding children and vulnerable adults.	
The wards Nominated Manager for Safeguarding Vulnerable Adults	Michael Creaney