The Regulation and Quality Improvement Authority

RQIA

Mental Health and Learning Disability

Unannounced Inspection

Donegore

Muckamore Abbey Hospital

Belfast Health and Social Care Trust

18 & 19 November 2014

national preventive mechanism

Contents

1.0 General Information

Ward Name	Donegore
Trust	Belfast Health and Social Care Trust
Hospital Address	Muckamore Abbey Hospital 1 Abbey Road Muckamore BT41 4SH
Ward Telephone number	028 94662836
Ward Manager	Rhona Brennan
Email address	rhona.brennan@belfasttrust.hscni.net
Person in charge on day of inspection	Rhona Brennan – Ward Sister
Category of Care	Learning Disability - Female Challenging Behaviour
Date of last inspection and inspection type	6 May 2014, Patient Experience Interviews
Name of inspector(s)	Wendy McGregor Kieran McCormick

2.0 Ward profile

Donegore is a nine bedded ward situated on the Muckamore Abbey Hospital site. The purpose of the ward is to provide care and treatment to female patients with a learning disability who present with challenging behaviours.

On the days of the inspection there were nine patients on the ward; six patients were detained in accordance the Mental Health (Northern Ireland) Order 1986.

Patients within Donegore ward receive input from a multidisciplinary team. This incorporates psychiatry; nursing; occupational therapy, pharmacy, psychology and behavioural support. Patients can access dietetics, podiatry and speech and language therapy by referral. Patients have access to on-site day care services. A patient advocacy service is also available.

On the days of the inspection, the inspectors noted the ward was welcoming. The ward was well lit, well maintained, clean and fresh smelling. There were separate day spaces and dining areas for patients.

All patients had their own individual ensuite bedroom. Patients' bedrooms were individualised with the patient's personal items. Entry and exit of the ward was via a swipe card system; access to the garden was also via the swipe card system.

There was a separate room for patients to meet with their visitors in private.

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, staff and relatives for their cooperation throughout the inspection process.

4.0 Review of action plans/progress

An unannounced inspection of Donegore was undertaken on 18 & 19 November 2014.

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

The recommendations made following the last announced inspection on 16 September 2013 were evaluated. The inspectors were pleased to note that all three recommendations had been fully met.

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

No recommendations were made following the patient experience interview on the 6 May 2014.

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

The recommendations made following the finance inspection on 31 December 2013 were evaluated. The inspectors were pleased to note that the recommendation made had been fully met.

4.4 Review of implementation of any recommendations made following the investigation of a Serious Adverse Incident

A serious adverse incident had occurred on the ward on 23 August 2013. Relevant recommendations made by the review team who investigated the incident were evaluated during this inspection.

Details of the above findings are included in Appendix 1.

5.0 Inspection Summary

Since the last inspection it was good to note that the new care plan format had been implemented and that patients' care records reviewed by the inspectors had been updated to reflect this. The inspectors were pleased to note that all recommendations made from previous inspections had been fully implemented. The inspectors were pleased to observe that staff treated patients with dignity and respect. There was evidence of patient outings and therapeutic activities on the ward. There was also evidence in care records of patient and family involvement in relation to decisions about patient care.

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.

The inspectors observed therapeutic engagement and activities between staff and patients, staff were discreet and responsive to patient's needs.

On the days of the inspection, information in relation to Capacity, Consent and Human Rights was available for staff and patients on the ward. Patient and/or relative involvement in all aspects of care was evident in the care documentation reviewed. Staff confirmed their knowledge of Capacity to Consent and informed the inspectors of the steps they took to ensure patients consented to care and treatment. Staff informed inspectors of how they would know if a patient was not consenting and the steps they would then take to ensure understanding. These included revisiting after a period of time or have another member of staff speak with the patient.

Care plans had been completed for particular physical health checks. There was reference made to use the best interest check lists or decision making tool. There was reference regarding obtaining consent before the health check, and the action to follow if a patient did not consent. The ward sister showed inspectors a new capacity assessment tool that she was piloting, feedback so far in relation to the tool was positive.

Capacity, Consent and Human Rights awareness are included in the ward induction programme. Staff that inspectors spoke to demonstrated an awareness of capacity, consent and Human Rights. Not all staff had attended training on Capacity, Consent and Human Rights, however inspectors were provided with dates of further training for those staff not trained. The ward also had a system in place for the sharing of information to all staff following training. This included group reflective practice sessions and provided all staff with an awareness of particular subjects.

There was evidence that staff had knowledge of patients' Human Rights, particularly Articles 3, 5, 8 and 14. There was evidence of these articles considered throughout patients care documentation.

Care records reviewed by inspectors showed evidence that each patient had an individualised assessment of needs and person centred care plan completed. Risk assessments and care plans were reviewed and updated six monthly or sooner if required by the multidisciplinary team. The multi-disciplinary template was completed by all staff and signatures of the patients and patients' relatives were consistently recorded. It was positive to note in daily care records reviewed that patients had been consistently consulted with in relation to their care. Care records evidenced patient's signatures and a note from staff that information had been explained.

Comprehensive risk screening tools were completed in accordance with Promoting Quality Care, Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services May 2010.

Where relevant, patients had an assessment of their communication needs and a communication passport completed. Staff demonstrated their knowledge of patients' communication needs and were familiar with patients' likes, dislikes and choices. There was evidence that where needed, speech and language therapy involvement had been sought for patients in relation to setting up communication aids/tools.

Patients had individualised assessments and plans for therapeutic and recreational activity plans. Information was displayed in relation to activities offered on the ward. Patients also had their own personalised daily schedules displayed in their bedrooms. Daily schedules provided a visual reminder for patients. Occupational Therapy (OT) assessments and reports were included in the patients' care documentation; OT recommendations were included in patients' care plans. Patient participation in activities was recorded in the daily progress notes and included detail of patients' reaction to particular activities.

Easy read information was available for patients in relation to: the patient's charter; complaints; independent advocacy services; keeping healthy including dentist and venepuncture; deprivation of liberty; capacity; and consent. The safeguarding vulnerable adult process was also discussed with patients in an easy read format. A ward information pack was available for patients and relatives. Staff were familiar with how to access and effectively utilise advocacy services. Advocacy involvement, where relevant, was documented in the patients care documentation.

Information in relation to the Human Rights Act was available to guide staff. All three ward staff interviewed demonstrated their awareness of patients' Human Rights in terms of their care and treatment. Consideration had been given to patients' Human Rights Articles 3, 5, 8 and 14 in patients care records.

Exit and entrance from the ward was locked and accessed using a swipe card system. A rationale was provided within each patients personalised restrictive practice care plans and are reviewed weekly by the multi-disciplinary team. Care plans demonstrated that the restrictions were the least restrictive option; care plans were signed by patients and where relevant, relatives.

Staff who met with inspectors demonstrated their knowledge and understanding of the Trust's policy and procedure on the use of restrictive practices and were familiar with the Deprivation Of Liberty Safeguards – Interim Guidance DHSSPS 2010.

Monthly reflective practice sessions are held; these provide an opportunity for staff to discuss recent incidents and to identify opportunities for learning or development that can be implemented as a result of an incident. The learning from incidents had also been shared at the bi-monthly team meetings.

There were two patients on the ward whose discharge was delayed. Community placements had been identified but the placements were not ready for the patients to move to. Discharge planning meetings occur on a 3

monthly basis. Inspectors were informed by the ward sister that discharge planning commences on admission in accordance with policy and procedure. Inspectors reviewed flowcharts to guide staff on the discharge pathway and process. Discharge care plans were individualised, detailed and had been reviewed every three months. When a community placement is sourced staff accompany patients during introductions to their new homes. Staff from the new facilities visit patients on the ward to get to know them. The ward sister advised that there were two patients on the ward who were delayed in their discharge from hospital. Both patients are waiting to move to placements in the community; however the identified places were not ready. The inspectors reviewed a copy of a completed 'All About Me Passport' for a patient who had an identified community placement. The passport aided in sharing information and enhancing a patient centred approach to transition into the community.

Details of the above findings are included in Appendix 2.

On this occasion Donegore has achieved an overall compliance level of **Compliant** in relation to the Human Rights inspection theme of "Autonomy".

Feedback of this inspection was discussed with the Acting Ward Sister, other ward staff and hospital personnel on the day of the inspection visit.

It was good to note that there are no recommendations as a result of this inspection.

6.0 Consultation processes

During the course of the inspection, inspectors were able to meet with:

Patients	**7**
Ward Staff	**3**
Relatives	**0**
Other Ward Professionals	**3**
Advocates	**0**

Patients

Inspectors spoke to seven patients. Patients stated they were happy on the ward. All patients stated they had been involved in their care and treatment; this was further evidenced from the review of individual care records. Patients informed inspectors about their daily activities and shared their individual daily schedules. Patients stated that they attend day opportunities during the week and they enjoy going each day. It was good to note that all patients were overall satisfied with the care they were receiving on the ward. Patients stated “I really like it here”, “staff are great and look after me”.

Relatives/Carers

There were no relatives available to meet with inspectors on the days of the unannounced inspection.

Ward Staff

Inspectors met with nursing staff on the ward. All staff stated they felt well supported and that the ward manager was approachable. All nursing staff were particularly complimentary of the ward sister, “fantastic, I can approach her about anything”, “100% supportive and is very approachable”. The nursing staff stated they felt involved in the operations of the ward and that any new information is shared amongst staff. Staff stated that they felt the ward had a great team ethos and that there is plenty of training and development opportunities. Nursing staff stated that patients were well cared for and that Donegore had a “very therapeutic environment” and that all patients are treated as individuals.

Other Ward Professionals

The inspectors met with the hospital senior social worker who spoke very highly of staff and the ward sister stating, “she is at the top of her game”. The

social worker informed inspectors that there is effective review of restrictive practices. He also stated, “Donegore was an enjoyable ward to work in and I don’t worry about this ward”.

The inspectors met with the consultant psychiatrist for the ward. The consultant informed inspectors that she attends the ward round every Monday. The consultant had no concerns regarding the ward and was complimentary of the staff and ward sister.

Inspectors met with the hospital Safeguarding Vulnerable Adults Designated Officer (DO). The DO stated that staff were familiar with the Safeguarding Vulnerable Adult policy and procedure and were making appropriate referrals in accordance with policy and procedure.
Inspectors discussed the 32 substantiated allegations with the DO. The DO confirmed that that none of the 32 allegations were outstanding. He advised that referrals for safeguarding investigation by ward staff had been promptly completed and that protection plans were put in place. The DO also advised that incidents had been appropriately reviewed in accordance with the trust safeguarding policy and procedure.

Advocates

There were no advocates available to meet with inspectors on the days of the unannounced 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	19
Other Ward Professionals	5	5
Relatives/carers	9	2

Ward Staff

19 questionnaires were returned by ward staff

It was good to note that information contained within the staff questionnaires demonstrated all staff were aware of the Deprivation of Liberty Safeguards (DOLS) – interim guidance. 17 of the 19 staff members had received training in restrictive practices and were aware of restrictive practices on the ward. Examples of restrictive practices as reported by staff included “locked ward” “low stimulus environment”, “1:1 observations”, and “MAPA”. All 19 staff members indicated they had received or had a date scheduled for training in the areas of human rights and capacity to consent.

All 19 staff members who returned their questionnaires prior to the inspection stated they had received training on meeting the needs of patients who need support with communication. Staff indicated that patient's communication needs are recorded in their assessment and care plan. They indicated they were aware of alternative methods of communicating with patients. All staff members reported that patients had access to therapeutic and recreational activities and that these programmes meet the patient's needs.

On the days of the inspection, the inspectors observed individualised therapeutic and meaningful recreational activities in place for all patients. There was evidence of alternative methods of communication used with patients and that patient's communication needs are recorded in their assessment and care plan.

Other Ward Professionals

Five questionnaires were returned by other ward professionals in advance of the inspection. It was noted that information contained within the professional's questionnaires demonstrated that all five professionals were aware of the Deprivation of Liberty Safeguards (DOLS) – interim guidance. Four of the five professionals had received training in restrictive practices and all staff indicated they were aware of restrictive practices on the ward. One professional stated "all restrictive practices are recognised in each individuals care plans and these are reviewed by the multi-disciplinary team". Four of the five professionals indicated they had received training in the areas of human rights and capacity to consent.

Three of the five ward professionals stated they had received training on meeting the needs of patients who need support with communication. All five professionals indicated that patient's communication needs are recorded in their assessment and care plan. They recorded that they were aware of alternative methods of communicating with patients. All professionals stated that these were used in the care setting and that the ward had processes in place to meet patients' individual communication needs. All five ward professionals reported that patients had access to therapeutic and recreational activities and that these programmes meet the patient's needs.

Relatives/carers

Two relatives returned questionnaires. Relative's comments included:

"Donegore provides an excellent level of care, my sister is doing very well because of the positive therapy and intervention she has received"

"the care and service seems very good, sometimes she wants me to see something in her room often I am not allowed, but I assume staff are accommodating the needs of other patients"

7.0 Additional matters examined/additional concerns noted

Complaints

The details of one complaint were sent to RQIA with the pre-inspection documentation. The inspectors reviewed the record of complaints held on the ward and in discussion with the ward sister clarified the details. The inspectors noted the complaint was ongoing and was being managed in accordance with policy and procedure.

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.

No requirements or recommendations resulted from the Patient Experience Interviews of **Donegore, Muckamore Abbey Hospital** which was undertaken on **18 & 19 November 2014** and I agree with the content of the report.

Please provide any additional comments or observations you may wish to make below:

NA

NAME OF REGISTERED MANAGER COMPLETING	Sr Rhona Brennan
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING	Michael McBride

Approved by:	**Date**
KIERAN MCCORMICK	23/12/14

Appendix 1

Follow-up on recommendations made following the announced inspection on 16 September 2013

No.	Reference.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	Section 1, standard 1.4, page 2	It is recommended that all Trust policies and procedures, relevant to the Donegore ward, are updated.	The inspectors reviewed the policies and procedures folder. The inspectors noted that all policies and procedures pertaining to Donegore ward were up to date.	**Fully met**
2	Section 2, standard 15.55, page 14	It is recommended that the new care plan format is implemented.	The inspectors reviewed care documentation relating to three of nine patients on the ward at the time of the inspection. It was noted that a new care plan format has been implemented on the ward since the September 2013 announced inspection on this ward.	**Fully met**
3	Section 4, standard 40.4, page 27	It is recommended that the ward's windows are regularly cleaned.	The inspectors undertook a review of the ward environment as part of the inspection. The inspectors did not identify any concerns regarding environmental cleanliness on the days of inspection. The ward manager informed the inspectors that external windows are cleaned three times per year and that the internal ward area is cleaned and maintained on a daily basis.	**Fully met**

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

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

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 maintains a record of all staff who obtain the key to the Bisley drawers where patient's money is stored and the reason for access	Inspectors reviewed records of staff obtaining keys to the Bisley drawer. Records evidence staff that access the key to the Bisley drawer and the reason for this access was recorded. A signature list is completed, with staff names, band and signature. The inspectors noted that the ward sister completed a weekly audit and the operational manager completed a monthly audit.	**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	BHSCT/SAI/13/59	Processes and procedures relating to interaction with the Coroner's Office to be clarified and strengthened.	The ward sister and consultant psychiatrist informed inspectors that contact had been made with the coroner's office to clarify processes. The Trust Bereavement Co-ordinator delivered an information session to staff and provided the ward with an information pack which included flow charts and guidance to assist them in the steps to take in the event of a death. Inspectors were informed by the ward sister and consultant psychiatrist that it	**Fully met**

			is the responsibility of medical staff to liaise with the coroner's office following the death of a patient.	
2	BHSCT/SAI/13/59	Staff to ensure that they document their discussion with the Coroner and/or Coroner's Medical Advisor where the cause of death is uncertain/sudden death	Inspectors were informed by the consultant psychiatrist that staff have been informed that they must document their discussions with the Coroner. There was a written record to evidence that this had taken place. Inspectors were advised by the consultant psychiatrist that this process will be monitored through the mortality/morbidity meetings.	**Fully met**
3	BHSCT/SAI/13/59	Senior Managers to organise awareness raising for staff in relation to post mortems, and the possibility of requesting a hospital post mortem when necessary.	Awareness training has been provided to staff by the Belfast Health and Social Care Trust Bereavement Co-ordinator.	**Fully met**
4	BHSCT/SAI/13/59	All staff to familiarise themselves with the information and procedures included within the Coroner's Office Bereavement Support Pack.	There was a bereavement support pack available on the ward. The inspectors reviewed the contents of the pack which included: support for staff, patients and relatives, sudden death guidance and the protocol to be taken after an in hospital death – a flowchart was available for staff reference on actions to be taken and procedure to be followed in the event of a death on the ward.	**Fully met**

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:	
Patients are assessed in relation to capacity to consent to treatment on an individual basis depending on the aspect of care being delivered. Staff work in collaboration with the patient in a person centred approach to assess capacity and obtain consent to treatment. Patients have a detailed person centred care plan which demonstrates their capacity to consent to care and treatment. If a patient has been assessed as not having the capacity to consent to care and treatment all avenues are explored to enhance the persons autonomy. If a patient is deemed as not having capacity the patients care plan will reflect how to deliver their care in the best interest of the patient as per DHSSPS guidance. The assessment of capacity in relation to serious decisions are discussed at the MDT meeting and recorded, in consultation with relevant others i.e. the patient and relatives/carers and advocates, and considering the persons best interest. Patient/ carers /relatives are involved in the completion and review of their care and treatment through a Person Centred approach to care planning/ CRA , positive risk taking and restrictive practice within the unit. A welcome pack is available on the ward and shared with new admissions and their relatives	Substantially Compliant

Easy read documentation available for patients and families. – i.e. consent, human rights, MHO & Deprivation of Liberty. Easy read documentation is used to enhance the patients autonomy in relation to their care. Donegore fully embrace family & relatives within the unit. Donegore is a locked ward however relatives are encouraged to be actively involved through open visiting, regular phone calls and invites to MDT meetings, annual reviews and CRA meetings. A visitors room is provided for families to visit their relatives. Donegore provide an annual open day to the ward for all relatives to visit their relatives living environment, relatives can visit patients bedroom on request. Named nurses liaise with families in relation to home visits on a regular basis. Staff work in collaboration with families in all aspect of patients care. Families receive a weekly update by a named nurse after MDT meetings, staff also inform families of all adult safeguarding referrals and any decision around capacity to consent to the VA process. Families are involved to make decisions collaboratively with patients and in the absence of capacity and act in the patients best interests in relation to the safeguarding process. Patients are encouraged to attend the MDT meetings weekly, CRA meeting 6 monthly and annual reviews. Patients can also contribute to the meeting verbally prior to it taking place if they choose not to attend. Patients have their own bedroom with en suite facilities. Patients have their own bedroom door key. 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 and Capacity & Consent training is available for staff through TAS all staff have been identified for training. Autonomy resource pack is available on the ward for staff in keeping with DHSS guidance. Staff are aware of their responsibility in relation to capacity and consent. Named nurses have therapeutic 1:1 sessions with patients on a weekly basis to optimise the patients understanding of their care and treatment. Where there is assessed need patients have a visual schedule.	

Patients' Finances and Private Property – Policy for Inpatients within Mental Health and Learning Disability Hospitals available in the ward. Patients financial capacity are individually risk assessed by the consultant.	
Inspection Findings: FOR RQIA INSPECTORS USE Only	
Inspectors noted information in relation to Capacity to Consent and Human Rights was available for staff, patients and visitors on the ward. Easy read information documents were available on the ward in relation to The Mental Health (Northern Ireland) Order 1986, Deprivation of Liberty, Human Rights and Capacity to Consent. The ward sister informed inspectors that easy read information leaflets are used to help enhance patients' autonomy and understanding in relation to their care. Inspectors reviewed care documentation relating to three of nine patients on the ward at the time of the inspection. It was good to note that: • staff had discussed each care plan with the patient • patient capacity to understand was recorded and evidence to support this was included in each patient's care documentation • patients reaction to information given about their care plans was also recorded, this included their response to information provided following MDT meetings. • attempts to revisit the plans were recorded • care plans reviewed had been signed by the patient there was evidence that patients' families had been involved in the completion of patient's care plans • relatives were invited to all monthly multi-disciplinary and resettlement meetings. The ward was promoting ongoing family involvement in assessment, care and treatment planning and evaluation • relatives' attendance and non-attendance at meetings was recorded • when relatives where unable to attend multi-disciplinary and resettlement meetings there was a record in care records of outcomes having been shared. One of the three patients' care records reviewed required a comprehensive risk assessment. Inspectors noted there was evidence that the assessment had been periodically updated in accordance with Promoting Quality Care Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services May 2010 Promoting Quality Care. Care records were individualised and had been consistently reviewed and evaluated on an ongoing basis by nursing staff and the MDT throughout the patient's admission, with reference and consideration given to the patients Human Rights. One of the patient's	Compliant

records evidenced minutes from a best interest's decision making meeting in relation to a proposed treatment plan. Where the patient was assessed as not having capacity to consent the decision was made by the Multi-disciplinary team (MDT). Relative involvement was seen as a positive action in keeping with best practice guidance. Inspectors spoke with three of the staff working on the ward on the days of the inspection. Staff demonstrated their knowledge of capacity to consent and informed the inspectors of the steps they took to ensure the patient consented to care and treatment e.g. take time to explain to the patient or, try again at a different time of the day. Staff informed the inspectors of the action they took if a patient showed signs that they were not consenting and stated they respected the patients' right to refuse the care and treatment. Staff interviewed stated that patients would also initiate or seek staff to assist them with certain care and treatment tasks, this would inform staff of the patient's wishes. Staff who spoke with inspectors were able to make reference to the Human Rights Act. Staff were able to explain to inspectors the manner of their work is conducted in a way that promotes the patient's right to respect for privacy and family life, (Article 8), this was also reflected in the patients care documentation. The policies, procedures and guidance in relation to Capacity and Consent and Human Rights were included in staff ward induction programme and were available for review. The ward sister confirmed that a group of staff nurses from the ward had attended Consent and Capacity training and that remaining staff nurses had been booked to attend on a further date. The ward sister informed inspectors that training is shared at ward level through group work and group sessions. Training records evidenced staff working on the ward had received training in Human Rights and Deprivation of Liberty.	

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 comprehensive person centred care plan, which includes a holistic person centred 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. Easy read information has been utilised throughout the care plan and is retained on the ward to enhance patients understanding of their care plan. Care plan reflects Human rights Issues. The Human Rights Act is available on the ward. Staff have an awareness of Article 8 & article 14 in relation to best practice. A guide to the Human Rights act and mental health order is available in easy read. A risk screening tool is completed and if deemed necessary by the MDT, patients will have a comprehensive risk assessment. The CRA is reviewed when there is a change in risk and at a minimum of 6 monthly. Review meetings are held in conjunction with families, where they are invited to attend and in their absence the named nurse shares the actions with the families. Any assessed risk is identified and reflected in the care plan, CRA and restrictive practice template.	Substantially Compliant

Staff are aware of the need to manage risk and any restrictions required is individually risk assessed and are proportionate to the level of risk posed. All patients have an advocate and are invited to attend CRA / Annual reviews. Patient forums are held every other month and advocates are invited to attend. 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 to have a communication passport. Patients are referred to Speech & Language on assessment of need. Communication training is available on TAS. Staff are trained in HABIT/ MAPA & STORM to enhance care delivery, reduce risk and promote patients ability to engage in their care. Staff nurses are trained in Promoting Quality Care training and deliver care in relation to this guidance. Positive risk taking is evident throughout the ward on an individual basis. Patients are referred to Psychology services on assessment of need. 2 patients have weekly 1:1 sessions with DBT therapists. 2 patients attend DBT sessions on a weekly basis.	
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
Inspectors reviewed care documentation relating to three of nine patients on the ward on the days of the inspection. Each patient had an individualised and holistic assessment of needs, comprehensive risk screening tool and person centred care plan completed, which reflected a person centred approach to care. Each patient's care plan had been developed to address identified assessed needs. Where restrictive interventions were required, these had been individually risk assessed. Risk assessments and care plans were reviewed and updated on at least a six monthly or more frequent basis if there were changes to the patients' needs. There was recorded evidence of patient and relative involvement in the patients' daily progress notes, in the three patients' care documentation reviewed there were records of patients, relatives/carers involvement in multi-disciplinary and discharge planning meetings. Care documentation reviewed evidenced that patient's views had been sought prior to multi-disciplinary meetings. There was evidence that staff had met with patients after the meeting to discuss the outcome, patients also had the opportunity to attend meetings and	Compliant

post meeting information was shared with patients in an easy read format. Comprehensive risk screening tools were completed all three sets of care documentation. This was completed in accordance with Promoting Quality Care Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services May 2010. In one set of care documentation reviewed the patient had an assessment of their communication needs and a communication passport completed. The communication passport was individualised, detailed and provided clear guidance on how to communicate with the patient and promote meaningful patient engagement. The three ward staff interviewed demonstrated their knowledge of patients communication needs. Staff were familiar with individual patient needs, their likes, dislikes and choices.	

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:	
Patients are individually risk assessed in relation to recreational / therapeutic activity programmes which is reflected in the Care Plan. All patients have individualised activity timetables. On assessment of need patients have a visual schedule to enhance therapeutic activity within the ward. Donegore has an activity coordinator to co – ordinate recreational activity within the ward. Patients attend day-care on a sessional basis – off the ward. If assessed as a need patients can avail of in reach day-care. There is a wide range of recreational activity available in the ward which can occur individually or in a group setting. Activities on offer include, table top activities, hair & beauty evenings, music therapy, multi sensory sessions and a weekly art & craft evening. Patients also have the opportunity to attend cookery sessions weekly off the ward in relation to Cook It Programme. Patients also can attend weekly swimming sessions. Donegore offer an activity evening "Monday Night Club". Patients have the opportunity to participate in physical exercise off the ward on a 1:1 basis or in a group setting in keeping with The Learning Disability Service Framework guidance. The Monday Night Club is patient centred and has demonstrated positive outcomes for patients. A project has been completed by the activity coordinator to evaluate the delivery of the evening. The activity evening also includes a Jewellery Teacher attending for a 3 week session at a time. Patients also have the opportunity to leave the site on an individual basis which is risk assessed by the MDT in relation to shopping, cinema, local gym and beautician appointments. Patient forums take place every other week and participation in recreational activity is discussed on the	Compliant

agenda. Patients are encouraged to have regular home visits. Staff work in collaboration with families/ relatives to achieve positive outcomes for both patients and their families. Patients can be referred to Occupational Therapy if required. 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	
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
Inspectors completed direct observations of the ward over the two day inspection period. Inspectors observed therapeutic activities taking place for patients on the ward. This included artwork, jigsaws and one to one time spent with named nurse. The inspectors observed all patients taking part in group activities with staff support. Inspectors were advised that additional day-care opportunities are provided for patients at Moyola, this was reflected on individual patient's timetables. Inspectors noted each patient had an individualised therapeutic and recreational weekly activity programme. Inspectors noted in the three sets of care documentation reviewed that each patients had recreational and therapeutic assessments and care plans completed. These correlated with each individual patient's daily schedule. Daily schedules acted as a reminder and guide to both patients and staff in carrying out activities. Inspectors were informed of activities that promoted patients individual identity, this included attending the beautician and hairdresser. Inspectors observed staff actively engaging with patients, communication and interaction was positive and all patients were treated with dignity and respect. Staff discreetly and promptly attended to patient's needs when assistance or support was required. Staff were observed completing enhanced observations with patients, and observed using this opportunity to engage meaningfully and therapeutically with the patient. There were records in individual patient's notes of 1-1 time spent with named nurse; a record of topics discussed was also included.	Compliant

Information was displayed in relation to all activities offered on the ward, individual patient timetables and schedules were displayed in patients' bedrooms in a format that met each the communication needs of each patient. Inspectors reviewed evidence of governance and improvement activity on the ward. Inspectors were shown an analysis and break down of incidents since the ward had opened. Evidence provided indicated that meaningful and person centred therapeutic engagement has been a contributing factor to a year on year reduction in incidents of physical aggression towards staff. Occupational Therapy (OT) assessments and reports were included in the patients care documentation and OT recommendations were included in the care plans. Patients' likes, dislikes and choices were included in the care documentation reviewed. Patient participation or otherwise was recorded in the daily progress notes and included detail of patients' reaction to particular activities. There was documented evidence that consideration was given to patients' rights to respect for private and family life and all records where completed giving consideration to human rights.	

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:	
Donegore work collaboratively with patients to empower them through involvement in their care with a patient centred approach. This is achieved by; care plan/ 1:1 therapeutic session with named nurse. Patients are aware of their rights through sharing of information and use of easy read leaflets; documents are available for patients and for use by staff / family / advocates. Easy read documentation includes MHO, Human Rights Act, Deprivation of Liberty, Levels of observations, How to make a complaint & 1st Steps to Vulnerable Adult process. 'You Muckamore Abbey and the law' is available on the ward. Easy read material is retained at ward level in a folder as well as a welcome pack for patients and relatives. The patient centred care plan is supported with easy read information. Patients with communication difficulties in relation to their diagnosis have visual schedules to structure their day and to enhance the holistic care. Patients are aware of any restrictions within the ward and are involved in the decision making in relation to restrictive practice documentation in the care plan in relation to Deprivation of Liberty interim guidance. Easy read Deprivation of Liberty has been shared with the patients to enhance their understanding of restrictions. The patients charter is available in the ward for patients and relatives - easy read	Compliant

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 . Patients are informed of their rights in relation to the detention process/ MHRT and easy read information is retained at ward level to enhance patients understanding of this process.	
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
It was good to note that easy read information was available on the ward for patients and relatives in relation to: the advocacy service; how to make a complaint; Capacity to Consent; The Mental Health (Northern Ireland) Order 1986; and, patient's rights when in hospital, which included their human rights in relation to articles 3, 5, 8 and 14. The ward information pack was also available in easy read format and included information on locked exit from the ward and information in relation to physical interventions. The patient's charter was available in the ward for patients and relatives in easy read format. Information regarding The Regulation and Quality Improvement Authority and the Mental Health Review Tribunal was also displayed throughout the ward. One patient that spoke with inspectors was able to indicate that they were aware of the complaints process, detention process and of their right to make an appeal to the Mental Health Review Tribunal; the same patient informed the inspectors that they had exercised this right. The ward sister and staff were familiar with how to access and effectively utilise advocacy services, there was evidence of advocacy involvement in the care documentation. Information in relation to the Human Rights Act was available for staff on the ward. There was evidence in the three patients care documentation that care plans had been created with consideration to patients Human Rights, in particular Article 5 right to liberty, Safeguarding Vulnerable Adults and Deprivation of Liberty.	Complaint

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 comprehensive person centred care plan. Patients' needs are individually assessed and if a restrictive practice is assessed as required to meet a need, a clear recorded rationale for its use is documented. Any use of restrictive practice within the ward reflects Deprivation of Liberty Interim guidance 2010. Patients are individually risk assessed in relation to any restriction that may be deemed necessary to maintain safety. Any restriction used is in proportionate to the level of risk. Restrictive practice is reflected in the care plan documentation in a Restrictive Practice template. Use of restrictive practice is agreed by the MDT and reviewed weekly at MDT meeting or sooner if the need arises. The restrictive practice template is reviewed 6 monthly or sooner depending on the level of risk posed with a view to reducing the restriction – patients, relatives, carers and advocates are encouraged to partake in the review. Staff have a knowledge of Deprivation of Liberty Interim Guidance and deliver care in relation to this. Staff have a positive ethos within Donegore and adopt a least restrictive option in relation to care delivery. The Human Rights Act is available in the ward, all staff are aware of and consider Articles 3, 5, 8 and 14	Compliant

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.	
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
Inspectors identified a number of restrictive practices in place on the ward. These included enhanced observations, access to personal monies, ward exit was locked and patients did not have free and open access throughout the ward including access to the garden area. In all three patients care records a comprehensive risk assessment had been completed. This included a clear rationale for the restriction. Restrictive Practice and Deprivation of Liberty care plans were in place for each restrictive practice in the care records relating to the three patients reviewed. There was reference to the Human Rights Act and respective articles, in particular Article 5, right to liberty. There was evidence of MDT review of the restrictions weekly; this is ongoing from the point of initial restrictive practice assessment. Care plans demonstrated that the restrictions were proportionate to the risk and the least restrictive measure, care plans were signed by patients' in each case. The three ward staff interviewed by inspectors demonstrated their knowledge and understanding of the Trust policy and procedure on the use of restrictive practices, staff were familiar with the Human Rights Act and Deprivation Of Liberty Safeguards – Interim Guidance DHSSPS 2010. A guide to The Human Rights Act was available on the ward in an easy read format and a deprivation of liberties easy read leaflet was also available. It was good to note that out of the 24 questionnaires which were completed by ward staff and visiting professionals prior to the inspection, 21 persons indicated that they had received training in relation to restrictive practice	Compliant

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:	
Discharge planning is commenced on admission into Donegore. Discharge Planning is reflected in the care plan documentation. Care Managers from owning trusts are invited to attend MDT meetings 3 monthly to provide a progress report on plans for discharge. Discharge planning considers the individually assessed needs of the patient - care managers attend these meetings. Relatives and patients are invited to and attend these meetings when placements are starting to be identified. If they do not attend the care manager communicates the discharge plan to the relatives following the meeting. Advocates are invited to and attend these meetings. Patients who have an identified community placement have a comprehensive "All About Me" completed to enhance a patient centred approach to the transition into the community. 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	
Inspectors were informed by the ward sister that discharge planning commences on admission in accordance with policy and procedure. The inspectors reviewed flowcharts to guide staff on the discharge pathway and process. Care managers from the owning Trust attend MDT meetings three monthly to provide a progress of regarding discharge. Minutes of meetings detailed those in attendance including family and where relevant independent advocates. Inspectors reviewed care records relating to three patients. Individualised discharge care plans were in place which are reviewed three monthly or sooner if required. Care plans were signed by the patient with consideration to the patients Human Rights recorded. Records evidenced the input from the MDT e.g. Occupational Therapy and Behaviour Therapy to support and prepare patients for discharge. The ward sister advised that there were two patients on the ward whose discharge was delayed. Community placements had been identified but the placements were not ready for the patients to move to. Inspectors noted a copy of a completed 'All About Me Passport' for a patient who had an identified community placement. The passport aided in enhancing a patient centred approach to the transition into the community through the sharing of information. Inspectors were informed that when a placement has been sourced staff from the ward accompany the patients during the introductions to their new homes. Staff record how patients react to their new environment and the guidance they gave to staff on how to care for the patient. Staff from the new facilities visit patients on the ward to familiarise themselves with the patients and familiarise the new staff about the patients care plans. The ward sister confirmed that the Health and Social Care Board are informed of delayed discharges.	Complaint