The Regulation and Quality Improvement Authority

RQIA

Mental Health and Learning Disability

Unannounced Inspection

Erne, Muckamore Abbey Hospital

Belfast Health and Social Care Trust

9 and 10 December 2014

npm national preventive mechanism

informing and improving health and social care
www.rqia.org.uk

Contents

1.0 General Information

Ward Name	Erne, Muckamore Abbey Hospital
Trust	Belfast Health and Social Care Trust
Hospital Address	1 Abbey Road Muckamore BT41 4SH
Ward Telephone number	028 95042087
Ward Manager	Helen Burke
Email address	helen.burke@belfasttrust.hscni.net
Person in charge on day of inspection	Helen Burke
Category of Care	Intellectual disability
Date of last inspection and inspection type	11 June 2014, Patient experience interview inspection
Name of inspector(s)	Alan Guthrie Dr SM Rea

2.0 Ward profile

The Erne ward is a 21 bedded mixed gender continuing care/resettlement ward located on the Muckamore Abbey Hospital site. As part of an ongoing resettlement process and associated reconfiguration on the hospital site, Erne, Ennis and Mallow wards were amalgamated in December 2013. This was followed by the amalgamation of the Greenan ward in October 2014. Inspectors were also informed that four patients had transferred from the Oldstone ward between July and September 2014.

There are patients from four Trust areas on the ward (Belfast, Northern, South Eastern and Western Trust). Resettlement meetings take place on a monthly basis for every patient. There is also a separate monthly multi-disciplinary meeting regarding each patient on the ward.

Patients within Erne receive input from a multi-disciplinary team which incorporates psychiatry; nursing; psychology; behavioural support and social work professionals. Patient and relative/carer advocacy services are also available.

At the time of the inspection two patients had been admitted to the ward in accordance to the Mental Health (Northern Ireland) Order 1986.

3.0 Introduction

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of Northern Ireland's health and social care services. RQIA was established under the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, to drive improvements for everyone using health and social care services. Additionally, RQIA is designated as one of the four Northern Ireland bodies that form part of the UK's National Preventive Mechanism (NPM). RQIA undertake a programme of regular visits to places of detention in order to prevent torture and other cruel, inhuman or degrading treatment or punishment, upholding the organisation's commitment to the United Nations Optional Protocol to the Convention Against Torture (OPCAT).

3.1 Purpose and Aim of the Inspection

The purpose of the inspection was to ensure that the service was compliant with relevant legislation, minimum standards and good practice indicators and to consider whether the service provided was in accordance with the patients' assessed needs and preferences. This was achieved through a process of analysis and evaluation of available evidence.

The aim of the inspection was to examine the policies, procedures, practices and monitoring arrangements for the provision of care and treatment, and to determine the ward's compliance with the following:

- The Mental Health (Northern Ireland) Order 1986;
- The Quality Standards for Health & Social Care: Supporting Good Governance and Best Practice in the HPSS, 2006
- The Human Rights Act 1998;
- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003;
- Optional Protocol to the Convention Against Torture (OPCAT) 2002.

Other published standards which guide best practice may also be referenced during the inspection process.

3.2 Methodology

RQIA has developed an approach which uses self-assessment, a critical tool for learning, as a method for preliminary assessment of achievement of the inspection standards.

Prior to the inspection RQIA forwarded the associated inspection documentation to the Trust, which allowed the ward the opportunity to demonstrate its ability to deliver a service against best practice indicators.

This included the assessment of the Trust's performance against an RQIA Compliance Scale, as outlined in Section 6.

The inspection process has three key parts; self-assessment, pre-inspection analysis and the visit undertaken by the inspector.

Specific methods/processes used in this inspection include the following:

- analysis of pre-inspection information;
- discussion with patients and/or representatives;
- discussion with multi-disciplinary staff and managers;
- examination of records;
- consultation with stakeholders;
- file audit; and
- evaluation and feedback.

Any other information received by RQIA about this service and the service delivery has also been considered by the inspector in preparing for this inspection.

The recommendations made during previous inspections were also assessed during this inspection to determine the Trust's progress towards compliance. A summary of these findings are included in section 4.0, and full details of these findings are included in Appendix 1.

An overall summary of the ward's performance against the human rights theme of Autonomy is in Section 5.0 and full details of the inspection findings are included in Appendix 2.

The inspector would like to thank the patients, staff and relatives for their cooperation throughout the inspection process.

4.0 Review of action plans/progress

An unannounced inspection of Erne was undertaken on 9 and 10 December 2014.

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

The recommendations made following the last unannounced inspection on 20 January 2014 were evaluated. The inspector was pleased to note that six recommendations had been fully met and compliance had been achieved in the following areas:

- the practice of locking patient wardrobes and chest of drawers had been stopped and all locks had been removed;
- patient assessments and care plans reviewed by inspectors evidenced that interventions were patient centred;
- patient care documentation had been reviewed and new patient care plans had been introduced;
- patients admitted to the ward in accordance to the Mental health (Northern Ireland) Order 1986 had a detention care plan which was used to monitor their detention;
- ward staff on Erne had received training on their role in relation to deprivation of liberty safeguards;
- patient deprivation of liberty safeguarding care plans included an explanation as to why a restrictive practice was necessary. Restrictive care plans reviewed by inspectors were noted to be based on the patient's assessed needs and reflected in the patient's care plan.

However, despite assurances for the Trust, one recommendation had not been fully implemented. The recommendation had been partially met and will require to be restated for a second time in the Quality Improvement Plan (QIP) accompanying this report.

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

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

- A record of staff who access the key to the Bisley drawer and the reason for access was maintained.

5.0 Inspection Summary

Since the last inspection the ward has addressed a number of previous recommendations and implemented a number of positive changes. These have included reducing the number of restrictions on the ward, improving records about the care and treatment patients received, introducing improved safeguards for patients and ensuring that patients admitted to the hospital in accordance to the Mental Health (Northern Ireland) Order 1986 have their legal status continually monitored and reviewed.

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.

Inspectors reviewed five sets of patient care documentation and noted that patient treatment and care needs, including the patient's capacity to consent to their care and treatment, were reviewed on a regular basis. Continuous care records, multi-disciplinary team meeting minutes and patient resettlement plans evidenced that a patient's capacity to consent was continually assessed and that decision making for patients lacking capacity was managed in accordance to regional and Trust guidance. However, inspectors noted that patient care documentation was not always completed within the required timeframe, patient and staff signatures were not always available where required and two sets of documentation contained records that were not properly secured. Inspectors were also concerned that care records were not formally audited. Recommendations regarding these issues have been made.

Medical files reviewed by inspectors evidenced that patients were seen by their Consultant Psychiatrist on a regular basis. However, inspectors noted that an overarching clinical summary of each patient's psychiatric and medical conditions was not available. A recommendation has been made.

Patient care records evidenced that patients were involved in their care and treatment and that treatment decisions and changes had been discussed and reviewed with them. Inspectors noted that patient care documentation included records detailing the involvement of patient's relatives/carers in the patient's treatment. Questionnaires returned by relatives prior to the inspection recorded that three of the four relatives felt that the treatment their relative received had been good. One relative did not provide an answer. During the inspection inspectors observed patients to be relaxed and at ease in their surroundings. Patient staff interactions were noted to be respectful, supportive and managed in a manner appropriate to the needs of the patient.

Patients on the Erne ward had an individual therapeutic activities plan completed in accordance to their assessed needs. Patients could attend the hospitals day care centre, the hospital's swimming pool and participate in ward based activities and activities away from the ward. The day centre manager informed inspectors that they felt the ward staff were supportive in relation to patient involvement in therapeutic activities. Patients on the ward could also access adult behavioural services, speech and language therapy,

pharmacy services and occupational therapy services as required. However, inspectors were informed that the Trust's psychology services based in the day care centre were not available to patients on the Erne ward. A recommendation has been made.

The ward provided a comprehensive range of information for patients in easy read format. Patients could also access an independent advocate. Inspectors were informed that the advocate visited the ward on a weekly basis and could be contacted as required Monday to Friday. During the inspection inspectors noted that two patients were admitted to the ward in accordance to the Mental Health (Northern Ireland) Order 1986. A detention care plan had been completed for each patient and this evidenced that patient care and treatment was being managed in accordance to the Order. The ward's patient welcome pack provided patients and carers with good information in relation to the ward's ethos and processes. However, the pack did not reflect changes within the ward nor did it detail the proposed plan for the ward's future function. A recommendation has been made.

The ward had implemented a number of changes in relation to the use of restrictive practices and inspectors noted that progress had been made in reducing the use of blanket restrictions. A number of internal doors had been unlocked and locks on patient wardrobes and chest of drawers had been removed. Inspectors also noted that where a restrictive practice was being used with a patient a restrictive practice care plan was completed in accordance to deprivation of liberty safeguards (DOLS). Plans examined by inspectors were noted to have been reviewed on a regular basis by the multi-disciplinary team. Staff who met with inspectors demonstrated appropriate knowledge and understanding of restrictive practices and awareness of DOLS guidance.

During the inspection inspectors noted that three of the ward's internal doors remained locked for significant periods of time. Patient care records reviewed by inspectors evidenced that the use of a locked door to support patients had been implemented in accordance to the assessed needs of the patients and DOLS guidelines. However, inspectors were concerned that the locking of three internal doors could be inappropriately restrictive to patients particularly patients who did not require the use of a locked door. A recommendation to review the use of locked doors will be restated for a second time.

Inspectors examined the ward's procedures for managing the use of physical intervention with patients. Inspectors noted the use of physical intervention within the ward was managed in accordance to regional and Trust policy. This included the completion of appropriate records and the provision of quarterly reports completed by the Trust's managing actual and potential aggression (MAPA) team. Staff training records detailed that 69 of the ward's 75 staff had completed up to date MAPA training. Refresher training had been identified for those staff requiring retraining. Staff who met with inspectors reported no concerns regarding their ability to access training. Inspectors noted that ward training records evidenced that 52 staff required

refresher training in relation to infection control. A recommendation has been made.

Twelve of the thirteen patients on the Erne ward were considered medically fit for discharge and were awaiting resettlement into community based services within their locality Trust. Inspectors were informed that eleven of the twelve patients ready to leave hospital would be discharged from the ward by August 2015. One patient did not have a discharge date as appropriate accommodation and community based support had not been identified for them. Patient care documentation reviewed by inspectors evidenced that a discharge plan had been developed for each patient and was reviewed on a monthly basis at the patient's resettlement meeting. The meeting was attended by the patient's relative/carer and staff from the patient's locality Trust. Inspectors were informed that the circumstances of each patient awaiting discharge from the ward were being continually reviewed by the Trust, the patient's locality Trust and the Health and Social care Board.

Details of the above findings are included in Appendix 2.

On this occasion Erne has achieved an overall compliance level of substantially compliant in relation to the Human Rights inspection theme of "Autonomy".

6.0 Consultation processes

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

Patients	6
Ward Staff	8
Relatives	2
Other Ward Professionals	1
Advocates	0

Patients

None of the patients' on the Erne ward spoke directly with inspectors. During the inspection inspectors spent long periods of time in the company of patients and observed patients and staff/ patient interactions. Patients observed on the ward and in the hospital day centre presented as relaxed and as being at ease in their surroundings. Patients were given appropriate time and space to make choices and to engage in daily and therapeutic activities. Staff were noted to be attentive and engaging with patients in a caring and considerate manner.

Relatives/Carers

Inspectors met with two relatives. Relatives informed inspectors that they felt their family member was safe on the ward and that staff were approachable and supportive. Relatives discussed their concerns regarding the continued change within the ward and the transition of patients moving in and out of the ward. Both relatives were concerned that their family members discharge from the ward and the transition back to their local community had not been 'thought through'. The relatives explained that they had discussed this with staff at the resettlement meeting and they would continue to do so. Inspectors discussed this with the ward manager and the assistant care manager and reviewed the ward's patient resettlement and discharge processes. From the evidence available on the days of the inspection inspectors were satisfied that the procedures for the management of a patient's discharge from the ward were appropriate and in accordance to Trust policy and procedure. Inspectors also noted that relatives were invited to patient resettlement meetings.

Ward Staff

Inspectors met with seven members of the ward's multi-disciplinary team (MDT). Nursing staff reported that the developments in the ward during the previous twelve months had been challenging. Nursing staff reflected that the amalgamation of wards and the subsequent admission of new patients and arrival of new staff had resulted in a period of continuous change. Nurses

reported no concerns regarding their ability to access supervision and training. The consultant psychiatrist reflected that the ward was focussed on supporting patients in their resettlement back to their locality Trust. The consultant reported that this was a shared ethos within the ward and was support by monthly resettlement meetings for each patient. The consultant also highlighted that there was good liaison with the general practitioners (GP) of patients who had resettled into their community. However, the consultant highlighted that patients within the ward did not received GP review. Subsequently, providing patients with clinical care in relation to diabetes monitoring, management of skin conditions, management of COPD and other medical screenings had been challenging for the ward's clinical team.

Staff comments included:

"…busy ward with a good team";

"The ward is much calmer at present";

"Patients have a wide range of needs";

"It's been challenging";

"The changes on the ward have been challenging and ongoing"

Other Ward Professionals

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

Advocates

The advocate was unavailable to meet with inspectors during the inspection.

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

Questionnaires issued to	Number issued	Number returned
Ward Staff	20	5
Other Ward Professionals	5	0
Relatives/carers	15	5

Ward Staff

Three nursing staff, a doctor and a day care worker returned questionnaires prior to the inspection. Each member of ward staff reported awareness of the restrictive practices used within the ward and four of the staff indicted that they had received training in relation to restrictive practice. Staff listed restrictive practices to include: the use of locked doors, observations,

controlled access to the ward and use of the Mental Health (Northern Ireland) Order 1986. All of the staff recorded that they had received training on meeting the needs of patients need support with communication. Staff also reported that they felt patient's individual therapeutic and activity needs were considered and appropriately addressed. All staff documented that patients on the ward could access therapeutic and recreational activities and activities were designed to meet patient's individual needs. Additional comments provided on the questionnaires included:

"Excellent ward which provides continuing care to some very complex and challenging individuals".

Other Ward Professionals

No other ward professionals returned questionnaires.

Relatives/carers

Four questionnaires were returned by relatives prior to the inspection. Three relatives commented that they felt that the treatment of patients on the ward was good and one relative did not provide an answer. Three relatives recorded that they felt they had not been offered the opportunity to be involved in decisions in relation to the care and treatment of patients. One relative stated that they had been involved. During the inspection inspectors noted that 12 of the 13 patients on the ward had a discharge plan completed and that relatives/carers were invited to attend the patient's monthly discharge planning meeting. Three of the four questionnaires retuned to RQIA by relatives recorded that two of the relatives had been involved in the patient's discharge plan and one relative had been given the opportunity to be involved in decision s regarding patient care and treatment. Three of the relatives indicated that the patient had an individual assessment completed in relation to therapeutic and recreational activity. One relative stated that they didn't know but the patient did attend the day centre. One relative provided comments on the questionnaire:

"Our relative has no capacity and family members are not offered any involvement except for the resettlement process";

"Our relative has no capacity and family got details of complaints system from citizens' advice";

"We received a form to complete in respect of the doctor and this has made us realise that no family member has been with our relative when any doctor from the hospital has been with our relative. We wonder if this common place in relation to patients with no capacity".

7.0 Additional matters examined/additional concerns noted

Complaints

No additional matters were examined/additional concerns noted during the inspection.

Complaints

Inspectors reviewed complaints received by the ward between the 1 April 2013 and the 31 March 2014. Two complaints had been received from relatives during this period. Both complaints related to concerns about the ward's environment. Both complaints were recorded as having been resolved to the full or partial 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.

8.0 RQIA Compliance Scale Guidance

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

Appendix 1 – Follow up on Previous Recommendations

The details of follow up on previously made recommendations contained within this report are an electronic copy. If you require a hard copy of this information please contact the RQIA Mental Health and Learning Disability Team:

Appendix 2 – Inspection Findings

The Inspection Findings contained within this report is an electronic copy. If you require a hard copy of this information please contact the RQIA Mental Health and Learning Disability Team:

Contact Details
Telephone: 028 90517500
Email: Team.MentalHealth@rqia.org.uk

Appendix 1

Follow-up on recommendations made following the unannounced inspection on 20 January 2014

No.	Recommendations	Number of times previously stated	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	It is recommended that the practice of locking wardrobes and chest of drawers is reviewed.	2	The practice of locking wardrobes and chest of drawers had been reviewed and this practice had been discontinued. The ward manager informed the inspector that the Trust's estate services department had attended the ward and removed all locks from patient wardrobes and chest of drawers. Inspectors reviewed four patient bedrooms and noted that none of the chest of drawers or wardrobes had locks.	Fully Met
2	It is recommended that patient's needs are reassessed to take account of their current presentation and that person-centred detailed care plans with individualised relevant interventions are developed.	2	Inspectors reviewed five sets of patient care documentation. Inspectors noted that since the last inspection patient needs had been reassessed and an updated care plan had been completed for each patient. Care plans reviewed by inspectors were noted to contain detailed and individualised interventions for each patient.	Fully Met
3	It is recommended that the ward sister ensures that care documentation relating to identified risks and presenting needs is formally reviewed and includes a review of any associated management plans.	2	Patient care documentation reviewed by inspectors evidenced that patient care plans, risk assessments and comprehensive risk assessments had been reviewed. Inspectors noted that the ward had introduced a new care plan proforma which included deprivation of liberty safeguard assessments and care and management plans specific to the individual needs of each patient. Patient management plans reviewed by inspectors addressed the individual needs of the patient as identified in the patient's assessment and risk assessment. Plans were noted to	Fully Met

			have been reviewed on a monthly basis by the multi-disciplinary team. Patient care management plans were also reviewed at each patient's resettlement meeting. The resettlement meetings were held on a monthly basis and attendees included patient's relatives/carers and staff from the patient's locality Trust.	
4	It is recommended that patients who are detained in hospital have a care plan relating to the monitoring of detention.	2	During the inspection inspectors noted that two patients were admitted to the ward in accordance to the Mental Health (Northern Ireland) Order 1986. Inspectors reviewed both patients care documentation and evidenced that detention care plans were available in each patient's file. The detention care plan included sections to support the continued monitoring of the patient's detention.	Fully Met
5	It is recommended that the ward sister ensures that staff working in Erne receive awareness training on their role in relation to Deprivation of Liberty Safeguards (DOLS) – Interim Guidance, as outlined by the DHSSPSNI in October 2010.	1	Inspectors were informed that the ward sister and deputy ward managers had completed Deprivation of Liberty Safeguards (DOLS) awareness training and had cascaded this training down to the Erne ward staff team. The ward had also introduced DOLS care plans for each patient and inspectors noted that these were reviewed by the multi-disciplinary team (MDT) as required and at the monthly MDT meeting. The ward's nursing staff training records evidenced that further human rights and DOLS training had been introduced by the Trust and all staff would receive training in the near future. At the time of the inspection training records evidenced that 12 of the ward's 75 staff had completed the training.	Fully Met
6	It is recommended that the Trust ensures that Deprivation of Liberty Safeguards (DOLS) – Interim	1	Patient care documentation reviewed by inspectors evidenced that each patient's individual needs had been assessed in accordance to DOLS guidance. A DOLS care plan was available for each patient and this detailed the use of restrictive practices	Fully met

	Guidance, as outlined by the DHSSPSNI in October 2010, is implemented within Erne.		and evidenced the rationale as to why the restriction(s) was necessary.	
7	It is recommended that the ward sister ensures that care plans in relation to actual or perceived deprivation of liberty are reviewed to ensure that an explanation of deprivation of liberty is included and relevant to the plan of care.	1	Deprivation of Liberty safeguarding care plans were available in each set of patient care documentation reviewed by inspectors. Inspectors noted that where a restrictive practice was being used with a patient a rationale for the use of the restriction was available. Inspectors reviewed the use of restrictive practices with each of the five patients and noted that the restrictions implemented were relevant to the patient's assessed needs as identified in their assessment and care plan. Inspectors assessed the restrictive practices used to be proportion, least restrictive and appropriate to promoting each patient's safety and wellbeing.	Fully Met
8	It is recommended that the Trust review all practices in the ward that could be considered restrictive, including the locking of internal doors, to ensure that all practices are the least restrictive most effective option to promote patient safety and wellbeing. Consideration of the impact on patient's human rights should be included as part of this review.	1	Inspectors were informed that a review of all practices that could be considered restrictive had been completed. A number of changes had been introduced within the including the removal of all locks from patient wardrobes and chest of drawers, the implementation of Deprivation of Liberty Safeguards (DOLS) care plans and the unlocking of a number of internal doors throughout the ward. Inspectors evidenced that the use of restrictive practices with patients had been individually assessed for each patient and were based on the patient's needs and the presenting risk. However, during the inspection inspectors noted that three internal doors remained locked for lengthy periods of time. This was evidenced as inspectors had to request that the doors be opened on several occasions during the inspection. Inspectors discussed the use of locked doors with the ward manager. The	Partially met

			manager explained that the locking of the three internal doors was necessary to ensure the safety and well- being of patients. Inspectors reviewed the care documentation of patients identified as requiring the use of a locked door. Inspectors evidenced that patient care plans and DOLS care plans recorded that the use of a locked door was required to support the patient. Inspectors were concerned that the locking of the three doors may not be the least restrictive most effective option to promote patient safety and well- being. This conclusion was based on the fact that the three doors were located in main corridors used by patients including those who had been assessed as not requiring the use of a locked door.	

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

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

Follow-up on recommendations made at the finance inspection on 31 December 2013

No.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	It is recommended that the ward manager ensures that a record of staff who access the key to the Bisley drawer, and the reason for access is maintained.	Inspectors reviewed the ward's procedures for the management of the Bisley drawer which was used to store patient monies and property. Inspectors evidenced that the drawer was being managed in accordance to Trust policy and procedure. This included retaining a written record of staff members who accessed the key and date, time and reason when the drawer was accessed.	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/14/68	(No Report as of yet - initial notification only)	N/A	N/A

R3

Quality Improvement Plan

Unannounced Inspection

Erne, Muckamore Abbey Hospital

9 and 10 December 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 hospital's clinical lead, the ward's consultant psychiatrist, the Trust's service improvement manager, the hospital's nurse manager and the ward manager on the day of the inspection visit.

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

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

	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
1	Criteria 6.3.2 (a)	It is recommended that the Trust review al practices in the ward that could be considered restrictive, including the locking of internal doors, to ensure that all practices are the least restrictive most effective option to promote patient safety and wellbeing. Consideration of the impact on patient's human rights should be included as part of this review.	2	28 February 2015	A review of practices in the ward that could be considered restrictive has taken place individually for each patient by the MDT. The locking of internal doors has also been reviewed. The door that links Erne to the annex (formerly Ennis) is now pemanently open. The other 2 doors are to remain locked for patients safety. This is individually care planned and agreed by the MDT for the patients concerned. Consideration of the impact on patient's human rights has been considered.

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

	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
2	Criteria 5.3.1 (a)	It is recommended that the ward manager ensures that patient care plans are reviewed in accordance to Trust standards and that care plan reviews are completed within the identified timescales. Outcomes from a patient's care plan review should be clearly documented and record patient progress and any change in the patient's circumstances.	1	Immediate and ongoing	The ward manager carries out monthly internal audits to monitor care documentation. An independent audit also takes place. Both audits monitors that reviews are completed within the identified timescales and that outcomes from a patient's care plan review is clearly documented and that there is a record of patient progress and any change in circumstances. An independent audit has been arranged for 10th February 2015. Learning from both these audits is shared with all staff in the ward.
3	Criteria 5.3.1 (f)	It is recommended that the ward manager ensures that patient and staff signatures are available where required. If a patient be unable to sign their care documentation this should be recorded.	1	Immediate and ongoing	The ward manager carries out monthly internal audits to monitor care documentation. The audit tool monitors that patient and staff signatures are available where required and if a patient is unable to sign their care documentation that this is recorded. An independent audit also monitors this recommendation. An independent audit has been arranged for 10th February 2015. Learning from both these audits is shared with all staff in 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.

	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
					ward.
4	Criteria 5.3.1 (f)	It is recommended that the ward manager ensures that patient care records are audited on a regular basis. Records of the audits, including the outcomes and any action taken, should be retained by the ward manager and shared with nursing staff.	1	Immediate and ongoing	The ward manager and deputy ward managers have scheduled a monthly audit of all nursing patient care records. Records of the audits, including the outcomes and any action taken, is be retained by the ward manager and learning shared with nursing staff.
5	Criteria 5.3.1 (a)	It is recommended that the consultant psychiatrist ensures that a clinical summary of each patient's psychiatric and medical conditions is made available in patient's medical records.	1	31 March 2015	The entire clinical team recognize the value of having an up-to-date list of diagnoses available for the patients. The new electronic record that has been introduced allows these to be held in one central location. The Consultant Pstchiatrist will ensure this is updated on an ongoing basis.
6	Criteria 5.3.1 (f)	The ward manager should ensure that patient information is properly secured within the patient's care records.	1	Immediate and ongoing	The ward manager carries out monthly internal audits to monitor care documentation. The audit tool used has been reviewed to reflect this

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

	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
					recommendation. The independent audit tool is currently being reviewed and updated.
7	Criteria 5.3.1 (a)	It is recommended that the Trust reviews the availability of psychology services to patients within the Erne ward and that the Trusts psychology services are made available to patients as required.	1	31 March 2015	The Trust is currently reviewing the commissioned and funded establishment of Psychology Services available to Erne ward and will expedite action necessary for any additional services to be urgently commissioned and deployed.
8	Criteria 6.3.2 (b)	It is recommended that the Trust updates the ward's patient /relatives information pack to reflect the ward's current position and future plans.	1	31 March 2015	The Ward Manager, Senior Nurse Manager in consultation with the MDT have reviewed the patient /relatives information pack to reflect the ward's current position and future plans.
9	Criteria 5.3.3 (d)	It is recommended that the ward manager ensures that nursing staff receive infection control training in accordance to Trust standards and a record of the training is maintained	1	31 March 2015	The ward manager ensures that nursing staff receive infection control training in accordance to Trust standards, since the inspection staff numbers in the ward have changed, the training record has been updated and staff no longer in the ward

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

	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
					removed, resulting in 42 staff requiring training. 20 staff have been booked places to attend training on 12th and 17th February. The remaining 22 have applied for places on 15th April, 12th May and 16th June, these places are to be confirmed by the IPC team

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	Helen Burke
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		Alan Guthrie	29 January 2015
B.	Further information requested from provider				