The Regulation and Quality Improvement Authority

Killead Ward

Muckamore Abbey Hospital

Belfast Health and Social Care Trust

Unannounced Inspection Report

Date of inspection: 24 April 2015

npm national preventive mechanism

Ward address: 1 Abbey Road, Muckamore, BT41 4SH

Ward Manager: Assumpta Cullinan

Telephone No: 028 9504 2080

Email: Assumpta.Cullinan@belfasttrust.hscni.net

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

RQIA Inspector(s): Alan Guthrie

Telephone No: 028 9051 7500

Our Vision, Purpose and Values

Vision

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

Purpose

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

Values

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

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

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

Contents

1.0 Introduction

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

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

Is Care Safe?

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

Is Care Effective?

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

Is Care Compassionate?

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

2.0 Purpose and Aim of this Inspection

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

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

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

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

2.1 What happens on inspection

What did the inspector do?

- reviewed the quality improvement plan sent to RQIA by the Trust following the last inspection
- talked to patients and staff
- observed staff practice on the days of the inspection
- looked at different types of documentation

At the end of the inspection the inspector:

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

After the inspection the ward staff will:

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

3.0 About the ward

Killead provides care and treatment to male patients with a learning disability who have an enduring mental illness.

On the days of the inspection there were 19 patients on the ward; four patients were detained under the Mental Health (Northern Ireland) Order 1986. Five patients were on enhanced observations.

Patients within Killead are supported by a multidisciplinary team which incorporates nursing, psychiatry, occupational therapy, psychology, behaviour support and social work professionals. Patients can also access an independent patient advocate as required.

During the inspection the inspector noted the ward to be well maintained, clean and fresh smelling. All patients had their own ensuite bedroom which were individualised with patients' personal items. Two separate areas of the ward were converted in small apartment style accommodation. One patient occupied each area. Both patients were receiving enhanced observations

Entry and exit to the ward was unrestricted during the hours of 9am to 6pm, after this time entry and exit is managed by staff.

4.0 Summary

Progress in implementing the recommendations made following the previous inspection carried out on 24 and 25 November 2014 was assessed during this inspection. There were a total of 14 recommendations made following the last inspection.

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

One recommendation had been partially met and four recommendations had not been met. Four of these recommendations will be restated for a third time and one recommendation will be restated for a second time following this inspection.

On the day of the inspection the inspector evidenced that the ward's atmosphere was welcoming and patients presented as being relaxed and at ease in their surroundings. Nursing staff were available throughout the ward and it was positive to note that staff were responsive, attentive and respectful in their interactions with patients.

Three sets of patient care documentation reviewed by the inspector evidenced that a comprehensive assessment of each patient's circumstances and needs had been completed. Patient progress records demonstrated that nursing staff continued to monitor each patient closely and involved patients and, were appropriate, the patient's carer/relative in the patient's care and treatment.

The inspector was concerned to note that two patient comprehensive risk assessments and three risk screening assessments had not been completed in accordance to regional guidelines. The inspector evidenced that patient comprehensive risk reviews had not taken place as required and the completion of one patient's comprehensive assessment had been delayed without explanation. The inspector also noted that MUST and Braden scale assessments available in each of the three files reviewed had not been reviewed in accordance to the required standard for patients receiving care and treatment in an acute setting. Two recommendations relating to patient's risk assessments and care records have been restated for a third time. One recommendation regarding risk screening tools has been restated for a second time.

It was good to note that a restrictive practice care plan had been completed for each patient. Plans detailed the type of restrictions used and the rationale for each restriction. The inspector noted that minutes of previous MDT assessment meetings, recorded in three sets of patient care records, did not include a review of the restrictions used with each patient. Subsequently, the inspector was unable to evidence, within the three files reviewed, that the MDT had reviewed the use of restrictive practices. Two recommendations regarding the use and monitoring of restrictive practices have been restated for a third time.

Given the lack of progress in implementing RQIA recommendations an escalation meeting was held with senior Trust representatives on the 8 May 2015. The Assistant Director Adult Social and Primary Care Services & Co-Director of Learning Disability Services, the Senior Manager, Service Improvement & Governance Adult Social & Primary Care Directorate and the Clinical / Therapeutic Service Manager attended.

The lack of progress in implementing five recommendations was discussed. It was positive to note that the Trust had taken appropriate steps to address the concerns highlighted in the report. An action plan detailing the Trust's response to address each of the recommendations restated will be forwarded to RQIA by the 29 May 2015.

4.1 Implementation of Recommendations

Five recommendations which relate to the key question "**Is Care Safe**?" were made following the inspection undertaken on 24 and 25 November 2014.

These recommendations concerned the completion of patient comprehensive risk assessments and record keeping.

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

- Patient records were being maintained in accordance to the Trust's records management and patient confidentiality policy;
- A continuous daily record of all aspects of care provided to patients was available in each set of care records reviewed by the inspector.

However, despite assurances from the Trust, three recommendations had not been fully implemented:

- Two comprehensive risk assessments had not been reviewed in accordance with regional guidelines;
- Not all of the patient care documentation reviewed by the inspector had been completed in accordance to published professional guidance on record keeping;
- Three risk screening tools had not been completed in accordance to regional guidelines.

Three recommendations which relate to the key question "**Is Care Effective**?" were made following the inspection undertaken on 24 and 25 November 2014.

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

- The Trust's patient finance and private property policy had been reviewed and amended. The amended policy included procedures to support patients, who lacked capacity, to make large purchases;
- A decision to transfer or admit a patient to or from another ward was taken by the multi-disciplinary team. Transfers of patients to the Killead

ward were completed in consultation with the patient and their representative(s).

However, despite assurances from the Trust, one recommendation had not been fully implemented:

- Care plans in relation to actual or perceived deprivation of liberty did not evidence that the multi-disciplinary team had considered proactive strategies to reduce the use of restrictions.

Six recommendations which relate to the key question "**Is Care Compassionate**?" were made following the inspection undertaken on 24 and 25 November 2014.

These recommendations concerned: care planning and the use of restrictive practices; decision making for patients who lacked capacity to choose; daily assessment of patient progress and the ward's complaints procedure.

The inspector was pleased to note that five recommendations had been fully implemented:

- Patients assessed needs were being fully met. This included the needs of patients presenting with other health concerns;
- Care plans in relation to deprivation of liberty had been discussed with patients and their representative(s) and this was evidenced in the patient's care records;
- There were appropriate arrangements in place in relation to decision making processes in support of patients who lacked capacity to choose. The processes were noted to be in accordance with DHSSPSNI guidance;
- Ward staff were continuing to assess patients consent to their daily care and treatment. This was evidenced in patient progress records and within patient care plans;
- Ward staff were recording and reviewing complaints received at ward level. Complaints were being managed in accordance to Trust policy and procedure.

However, despite assurances from the Trust, one recommendation had not been fully implemented:

- Care plans in relation to actual or perceived deprivation of liberty were not being reviewed by the multi-disciplinary team.

5.0 Ward Environment

"A physical environment that is fit for purpose delivering a relaxed, comfortable, safe and predictable environment is essential to patient recovery

and can be fostered through physical surroundings." Do the right thing: How to judge a good ward. (Ten standards for adult-in-patient mental health care RCPHYSH June 2011)
The inspector assessed the ward's physical environment using a ward observational tool and check list.

Summary

During the inspection the inspector noted that staffing levels were appropriate to the assessed needs of the patients. The main ward areas were clean and clutter free and the atmosphere was relaxed and welcoming. Staff were available throughout the ward and patients could access the support of a staff member as required. Patients' bedrooms had been well maintained and the bathrooms were clean and odour free.

It was good to note that patients could move freely throughout the ward and could access their bedrooms and the ward's garden area as required. There was signage on entry to the ward and on the internal doors indicating the purpose of each room.

The ward's notice boards were well maintained and included information on how to make a complaint, the advocacy service and the ward staff on duty. Information was also displayed regarding what daily activities were available. It was good to note that patients could access information in easy read format.

The ward had pictorial food charts with makaton signs and words to assist the patients in choosing what they wanted to eat each day. It was positive to note that staff supported patients with communication difficulties to make their daily meal choice.

5.1 Observation Session

Communication and behaviour is a vitally important component of dignified care. The Quality of Interaction Schedule (QUIS) is a method of systematically observing and recording interactions whilst remaining a non-participant. It aims to help evaluate the type of communication and the quality of communication that takes place on the ward between patients, staff, and visitors.

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

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

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

Neutral – brief indifferent interactions

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

Summary

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

Positive	Basic	Neutral	Negative
100%	0%	0%	0%

The inspector's observations evidenced positive interactions between patients and nursing staff. The inspector noted that staff were continually available throughout the ward and responded to patients' requests promptly. The inspector witnessed that staff remained supportive and reassuring to patients throughout the day. Patients were encouraged to speak with the inspector in private.

The inspector noted that patients remained relaxed and at ease in the company of nursing staff. Communication and conversations between patients and staff were informal, relaxed and friendly. It was positive to note that nursing staff demonstrated a high level of skill during their interactions with patients.

The detailed findings from the observation session are included in Appendix 2.

6.0 Patient Experience Interviews

Five patients agreed to meet with the inspector to talk about their care, treatment and experience as a patient. Two patients volunteered to complete a questionnaire.

Patients who met with the inspector stated that they knew the purpose of the ward and the reason why they had been admitted. Three patients reported that they had been given the opportunity to be involved in their care and treatment. Two patients did not provide an answer. Both patients told the inspector that they liked the staff and if they were not happy or if they were upset they felt the staff would help them.

Patients explained that they knew what an advocacy service was and they could speak to the advocate as required. It was positive to note that patients felt safe on the ward and patients presented as being comfortable and at

ease. Each patient reported positively regarding the care and support they received from staff. Patient's comments included:

"Advocate comes when we want to speak to them";

"I love the ward, it's very good";

"I think the ward is sometimes good and sometimes bad";

"You get plenty to eat".

The patient, who commented that they felt the ward was good and bad, stated that they were reflecting on the ward's noise level. The patient reported no concerns regarding the care and treatment they received.

Patients who met with the inspector detailed that they would know who to talk to if they had a concern or something was making them unhappy. Each patient reported that they were satisfied with the quality of the care and treatment they had received during their admission. Patients who completed the questionnaire gave the ward ten out of ten.

7.0 Other areas examined

During the course of the inspection the inspector met with:

Ward Staff	6
Other ward professionals	0
Advocates	0

Ward staff told the inspector that the ward was very busy and provided care and treatment to patients with a broad range of needs. Staff were complimentary regarding the support they received from colleagues and managers. Staff reported no concerns regarding their ability to access training and supervisory support.

The ward's rota recorded that there were three daily shifts for nursing staff. Shifts included the need for eleven nursing staff in the morning, ten in the afternoon and ten up until 23.00pm. Subsequently, the ward required a large nursing staff team. The inspector was informed that the management of the ward's high staff to patient ratios remained challenging.

The inspector was assured by the Ward Manager and the Clinical /Therapeutic Service Manager that staffing ratios continued to be closely monitored. The inspector was informed that the Trust continued to actively recruit new staff.

Staff reported to the inspector they had no concerns regarding the quality of care and treatment provided to patients. Staff stated that they felt patients on Killead were well cared for.

8.0 Next Steps

A Quality Improvement Plan (QIP) which details the areas identified for improvement has been sent to the ward. The Trust, in conjunction with ward staff, must complete the QIP detailing the actions to be taken to address the areas identified and return the QIP to RQIA by 19 June 2015.

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

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

Appendix 1 – Follow up on Previous Recommendations

Appendix 2 – QUIS

Follow-up on recommendations made following the Unannounced inspection on 24 and 25 November 2014

No.	Reference.	Recommendations	Number of times stated	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1		It is recommended that the Ward Manager ensures all comprehensive risk assessments are reviewed in keeping with regional guidelines.	2	The inspector reviewed two sets of patient care records in relation to the completion of a comprehensive risk assessment. One patient's risk assessment had not been reviewed. In accordance to Promoting Quality Care guidance (DHSSPSNI, 2010) *'The level of risk and success of the management plan will determine the frequency of review, but in general it is expected that reviews should take place at least 6-monthly for those who have had a comprehensive or specialised risk assessment completed'.* The inspector noted that the patient had complex needs and presented with significant risk factors. A handwritten note at the top of the first page of the patient's comprehensive risk assessment indicated that a review should have been completed on the 14 March 2015. The review had not taken place. The second patient file reviewed evidenced that the patient had been transferred to the ward on the 26 March 2015. A risk screening tool had been completed in the ward the patient was previously admitted to on the 8 December 2014. The screening tool indicated that the patient presented with significant risk factors. The patient had a history of self-injurious behaviour and	Not met

				presented with risk of harm to others including numerous assaults on other service users, family and staff. The risk screening tool also detailed that the patient had complex physical health needs. The risk screening tool had not been updated since the patient's transfer. Promoting Quality Care Guidance advises that in completing a comprehensive risk assessment and management plan '*The key worker should ensure that the process of risk assessment and the development of the risk management plan is completed within 28 days of the risk screen being completed'.* The risk screening tool contained a hand written note detailing that the decision to complete a comprehensive risk assessment would be taken after the ward's multi-discilnary team had met on the 16 December 2014. Recorded on the same page the inspector noted that the assessor had also indicated that a comprehensive assessment was not required. The risk screening tool did not record what action would be taken to manage the identified risks associated with the patient. This was contradictory and confusing. Furthermore, in the absence of a comprehensive risk assessment the inspector could not evidence how the patient's presenting risk factors were being managed and what actions had been agreed by the multi-disciplinary team. The inspector discussed the absence of a comprehensive risk assessment with the Ward Manager. The inspector was advised that a	

				comprehensive risk assessment was currently being completed with the patient.	
2		It is recommended the Ward Manager ensures that staff complete documentation in line with published professional guidance on record keeping.	2	As discussed above the required procedures for the completion of comprehensive risk assessments had not been adhered to in two sets of records. The inspector also evidenced that patient risk screening tools, recorded in three sets of patient care records, had not been completed in accordance to regional guidance One risk screening tool had not been signed by the patient; also there was no indication as to who assumed lead responsibility for the actions required in relation to the implementation of the immediate risk management plan. A second risk screening tool had been completed 7 June 2014 and reviewed 10 March 2015. The review in March 2015 was completed on the same screening tool used to record the risk screening carried out in June 2014. The inspector was unable to ascertain if the presenting risks had been reassessed in March 2015. For example, the screening tool completed in June 2014 indicated that a report regarding the patient's dental assessment was unavailable. The risk screening completed in March 2015 did not indicate if the report had been made available and the entry completed in June 2014 had remained unchanged. The inspector concluded that the risk screening	Not met

				completed in March 2015 had repeated the assessment completed in June 2014 without having fully considered the changes in risk to the patient during the interim period. A third risk screening tool reviewed by the inspector had been completed on the 7 April 2014. The tool had not been updated during the previous twelve months and there was no record of the decision making process regarding the completion of a comprehensive risk assessment. This was despite the patient having been assessed as presenting with significant risk factors in relation to harm to self or others, neglect and vulnerability, relationships with others, dissocial and offending behaviour, disengagement and environmental risk. The inspector also noted that malutration universal screening tool (MUST) and Braden scale assessments (predicting pressure sore charts) available in each of the files reviewed had not been completed in accordance to the required standard.	
3		It is recommended the Ward Manager ensures patients with additional needs are fully assessed, particularly where there is evidence of comorbidity issues to ensure the needs of the patients are fully met.	2	Care records reviewed by the inspector demonstrated that a comprehensive and holistic needs assessment had been completed for each patient. Two patient care records evidenced that the patients had comorbid physical health problems requiring ongoing treatment interventions. Both patient files evidenced comprehensive care plans to address the patient's individual needs. Patient progress records demonstrated that ward staff reviewed	Fully met

				the patient's circumstances and needs on a daily basis. Each patient's progress was reviewed by the ward's multi-disciplinary team (MDT) every two weeks. MDT records reviewed by the inspector evidenced tha the MDT continued to provide care and support in accordance to each patient's assessed needs.	
4		It is recommended the Ward Manager ensures that care plans in relation to actual or perceived deprivation of liberty are reviewed to ensure that the rationale and therapeutic aim is included in the relevant care plan.	2	Patient care records reviewed by the inspector evidenced that a restrictive practice care plan had been completed for each patient. Plans detailed the type of restrictions used and the rationale for each restriction. It was good to note that patient progress records evidenced that nursing staff continually reviewed the use of restrictive practices. This included records of discussions with patients about the restriction(s) used. The inspector also evidenced that nursing staff provided an updated rationale as to why a restriction remained in place. The MDT record template directed that the patient's human rights be considered in relation to the restrictive care plan and use of restrictive practices, physical interventions and medication. The inspector noted that minutes of MDT assessment meetings recorded in three sets of patient care records did not include a review of the restrictions used with each patient. One set of patient records evidenced that a restrictive practice care plan had been completed 4 April 2014. The care plan detailed the restrictions used to support the patient. These included the requirement that the	Partially met

				patient is nursed separately in a locked area of the ward, that the patient remains under level three observation with two members of staff supporting them and that the patient's wardrobe in their bedroom remains locked. MDT review records for the patient from the 19 March 2015, 2 April 2015 and 16 April 2015 were examined. The minutes dated 19 March and 2 April recorded that the patient was on level 3 observations from 0725 to 2200. The inspector noted that the other restrictive practices implemented as part of the patient's care and treatment had not been reviewed by the MDT. There was no record within the three sets of MDT minutes to evidence consideration of proactive strategies to reduce the need for restrictive practices with the patient.	
5		It is recommended the Ward Manager ensures the care plans in relation to actual or perceived deprivation of liberty are reviewed to include evidence of proactive strategies considered to reduce the restriction.	2	The inspector reviewed three sets of patient care records. Each record contained a comprehensive assessment, a risk assessment, care plans, multi-disciplinary team review meeting minutes and a restrictive practice care plan. Patient progress records reviewed by the inspector evidenced that nursing staff continually gave consideration to the use of restrictive practices. Records demonstrated that nursing staff continued to reflect on the need for restrictive practices with each patient. This included recording the rationale and context when the use of a restriction had been/remained necessary. However, there was no record within the three sets of	Not met

				multi-disciplinary minutes reviewed by the inspector to evidence consideration of proactive strategies to reduce the use of restrictive practices.	
6		It is recommended that the Ward Manager ensures care plans in relation to actual or perceived deprivation of liberty are discussed with patients and their representatives and this is documented in the care documentation.	2	Care plans and progress records reviewed by the inspector evidenced that restrictive intervention care plans had been discussed with patients' and their representatives. It was positive to note that nursing care records demonstrated continued contact with patients' relatives. This included providing relatives with updates when the patient required the use of a restrictive practice or when there was change in the patient's circumstances.	Fully met
7		It is recommended the Ward Manager ensures that only information pertaining to individual patients is stored within their own respective care files, in accordance with the Trusts Records Management and Patient Confidentiality policy.	1	The inspector reviewed three sets of patient care records. The information contained in each set of care records was appropriate to the named patient. The inspector noted no concerns in relation to a breech of the Trust's Records Management and Patient Confidentiality policy.	Fully met
8		It is recommended that the Trust review and amend the current Patient Finances and Private Property policy to reflect the process for those patients with or without capacity who wish to make large purchases.	1	The Trust's Patients' Finances and Private Property-Policy for Inpatients within Mental Health and Learning Disability hospitals was available. The policy had been approved from the 3 April 2015. Sections 4.2 and 4.3 of the policy detailed the procedures for supporting patients who lacked capacity and who wished to make large purchases. The inspector noted that in circumstances where a large	Fully met

				purchase was being made on behalf of a patient the Trust's senior management team were accountable for the expenditure. A senior nurse manager/operations manager sanctioned withdrawals up to £500. Larger amounts required the signature of the hospital services manager or the co-director/director.	
9		It is recommended that the Ward Manager ensures that there is a detailed continuous daily record of all aspects of care provided to patients, this should be completed in accordance with professional body guidance.	1	The ward was in the process of transferring patient records from paper copy onto electronic format. The Trust's PARIS electronic patient information system had been introduced to the ward from the 1 January 2015. Patient progress records reviewed by the inspector evidenced that a daily record of all aspects of patient care was being maintained. Each member of the ward's multi-disciplinary team updated each patient's care records as required. The Trust was continuing to implement the PARIS system and the inspector was informed that other professionals visiting the ward would also be updating patient care records on the PARIS system. This included staff from dentistry and dietetics services.	Fully met
10		It is recommended that the Ward Manager ensures that there are arrangements in place in relation to decision making processes in accordance with DHSSPS guidance. This should be recorded in care notes for those patients assessed as not	1	The DHSSPSNI capacity and consent guidance was available on the Trust's electronic information HUB. The inspector was informed that all staff had an email address and could access the HUB as required. The inspector reviewed the care records of two patients who had been assessed as lacking the capacity to consent to their care and treatment. The ward's care plan template directed staff to ensure	Fully met

		having capacity to consent to care and treatment.		that the procedure for considering the patient's best interests in the absence of the patient's capacity to chose is considered. Patient care plans reviewed by the inspector demonstrated that nursing care interventions were completed in the best interests of the patients. For example one care plan in relation to a patient's challenging behaviour recorded that staff must consider the use of de-escalation and distraction techniques and that all interventions should be explained to the patient. Patient progress records evidenced that ward staff reviewed and discussed each patients care and treatment with the them. Decisions taken on behalf of patients were reviewed daily by nursing staff and fortnightly by the ward's multi-disciplinary team. Patient care records evidenced that an assessment of a patient's capacity was completed prior to decisions being taken on behalf of a patient. Decisions made on behalf of a patient were discussed and agreed by the multi-disciplinary team. Patients care records also contained a financial capacity assessment. This included the arrangements for ensuring that patients money and property were safeguarded. The inspector noted that financial and property arrangements for patients had been implemented in accordance to Trust policy and procedure.	
11		It is recommended that the	1	Patient progress notes reviewed by the inspector	Fully met

		Ward Manager ensures that staff assess patients consent to daily care and treatment, this should be recorded in the patients individual care plans and continuous nursing notes.		evidenced that nursing staff continually assessed each patient's presentation and the patient's ability to consent to their care and treatment. Records evidenced that patients were consulted about their care and treatment on a daily basis. Care plans for each patient were retained on the Trust's PARIS system. Care plans identified the assessed needs of the patient and referenced the patient's preferences and choices. For example in one care plan in relation to the patient's use of medication the nursing intervention detailed that staff "Gain consent from (patient's name)" prior to dispensing their medication. Another care plan in relation to a patient's social care stated that staff continue to liaise with the patient regarding the patient's social needs. The continued care plan assessment evidenced that the patient's decision not to attend day care was respected and that care decisions were not taken without the patient's consent.	
12		It is recommended that the Ward Manager ensures that risk screening tools are completed in full. If a decision is made not to proceed to a full comprehensive risk assessment then a clear rationale must be recorded and signed by all relevant parties, as outlined in the	1	The inspector reviewed three patient risk screening assessments: One patient had been admitted four weeks prior to the inspection and their risk assessment was being updated. The patient had been transferred from another ward within the hospital. The patient's previous risk screening tool had been completed on the 8 December 2014. All sections of the tool had been completed and the tool	Not met

		Promoting Quality Care Guidance Document – Good Practice on the Assessment and Management of Risk in Mental Health and Learning Disability Services- May 2010.		had been signed by a member of staff. There was no patient or carer signature and a handwritten entry recorded that "Decision regarding a comprehensive risk assessment to be reviewed after 16 December 2014". The risk screening tool also recorded that a comprehensive risk assessment was not necessary contradicting the handwritten note located on the same page. A second patient risk screening tool had been completed on the 7 April 2014. The tool had not been updated during the previous year and there was no record of the decision making process regarding the completion of a comprehensive assessment. This was despite the patient being assessed as presenting with significant risk factors. The third risk screening tool had been completed on the 7 June 2014. The risk assessment was then updated on the 10 March 2015. The updated assessment had been completed using the original risk screening tool. The outcome of the updated risk screening assessment was not clear. The inspector was unable to evidence if the risk factors identified on the 14 June 2014 had been reconsidered during the risk screening assessment completed on the 15 March 2015.	
13		It is recommended that the Trust ensures that the decision to transfer patients to Killead from other wards is discussed and recorded as part of a	1	The inspector reviewed the care records of one patient who had been transferred to Killead from another ward in December 2014. The patient had been admitted to Killead at short notice due to a bed management issue. The transfer had been completed in accordance to Trust policy and procedure.	Fully met

		multi-disciplinary team assessment and review. Patient, relative and advocacy views should be sought prior to the transfer of a patient. This should be clearly documented in the patients care records.		The patient's care records evidenced that their transfer had been discussed with them and their relative prior to the transfer being completed.	
14		It is recommended that the Ward Manager ensures that the local resolution pro-forma is completed and retained upon resolution of a complaint.	1	The inspector reviewed the ward's arrangements for managing complaints. Information and guidance regarding the Trust's complaints procedure was available on two of the ward's notice boards. The Ward Manager had introduced a service group complaint/enquiry record form. This was used to record complaints made to the ward directly. Complaints records reviewed by the inspector had been completed appropriately and a copy of the complaint had been forwarded to the Trust's complaints department.	Fully met

Quality Improvement Plan

Unannounced Inspection

Killead Ward, Muckamore Abbey

24 April 2015

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

The specific actions set out in the Quality Improvement Plan were discussed with the Ward Manager, the Clinical Therapeutic Services Manager and other hospital personnel 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.

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
Is Care Safe?					
1	Section 5.3.1(a)	It is recommended that the ward manager ensures all comprehensive risk assessments are reviewed in keeping with regional guidelines.	3	Immediate and ongoing	A Multi disciplinary process has been impletmented to ensure, at least, six monthly reviews take place. All patients risk assessments have been reviewed by the multi-disciplinary team. All reviews are up to date. The ward manager will carry out a monthly audit of risk assessments
2	Section 5.3.1(f)	It is recommended the ward manager ensures that staff complete documentation in line with published professional guidance on record keeping.	3	Immediate and ongoing	Documentation has been completed in line with published professional guidance on record keeping. The ward manager will carry out a monthly internal audit to monitor care documentation. The audit monitors that staff complete documentation in line with published professional guidance on record keeping. Documentation has been completed in line with published professional guidance on record keeping.
3	Section 5.3.3(b)	It is recommended that the Ward Manager ensures that risk screening tools are completed in full. If a decision is made not to proceed to a full comprehensive risk assessment then a clear	2	Immediate and ongoing	Risk screening tools are now completed in full. The ward manager, through the on-going monthly audit will ensure that risk screening tools are always completed in full. Where a decision is made not to proceed to a full comprehensive risk assessment a clear rationale has been recorded on the

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
Is Care Safe?					
		rationale must be recorded and signed by all relevant parties, as outlined in the Promoting Quality Care Guidance Document – Good Practice on the Assessment and Management of Risk in Mental Health and Learning Disability Services- May 2010.			risk screening tool.
Is Care Effective?					
4	Section 6.3.2	It is recommended the ward manager ensures the care plans in relation to actual or perceived deprivation of liberty are reviewed to include evidence of proactive strategies considered to reduce the restriction.	3	Immediate and ongoing	Care plans in relation to actual or perceived deprivation of liberty have been reviewed and where applicable proactive strategies have been put in place to reduce the restriction. The ward manager will carry out monthly internal audit to monitor care documentation. The audits address that care planning in relation to actual or perceived deprivation of liberty is reviewed .

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
Is Care Safe?					
Is Care Compassionate?					
5	Section 6.3.2	It is recommended the ward manager ensures that care plans in relation to actual or perceived deprivation of liberty are reviewed to ensure that the rationale and therapeutic aim is included in the relevant care plan.	3	Immediate and ongoing	Care plans in relation to actual or perceived deprivation of liberty have been reviewed and the rationale and therapeutic aim is included in the relevant care plans. Deprivation of liberty and Restrictive Practice is now a standing agenda item on multi-disciplinary team meetings, and is included on the proforma used by each team. The ward manager will ensure this process will continue through monthly internal audits to monitor care documentation.

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	Assumpta Cullinan
NAME OF CHIEF EXECUTIVE / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Martin Dillon

Inspector assessment of returned QIP		**Yes**	**No**	**Inspector**	**Date**
A.	Quality Improvement Plan response assessed by inspector as acceptable	x		Alan Guthrie	**18 June 2015**
B.	Further information requested from provider				