RQIA

Mental Health and Learning Disability

Unannounced Inspection

Killead Ward, Muckamore Abbey Hospital

Belfast Health and Social Care Trust

24 & 25 November 2014

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1.0 General Information

Ward Name	Killead Ward
Trust	Belfast Health and Social Care Trust
Hospital Address	1 Abbey Road Muckamore BT41 4SH
Ward Telephone number	028 94662845
Ward Manager	Assumpta Cullinan
Email address	Assumpta.Cullinan@belfasttrust.hscni.net
Person in charge on day of inspection	Ray Rafferty – Acting Charge Nurse
Category of Care	Learning Disability - Male Assessment and Treatment
Date of last inspection and inspection type	25 June 2014, Patient Experience Interviews
Name of inspector(s)	Wendy McGregor Kieran McCormick

2.0 Ward profile

Killead is a male ward situated on the Muckamore Abbey hospital site. The purpose of the ward is to provide treatment to patients with a learning disability who have an enduring mental illness.

On the days of the inspection there were 20 patients on the ward; two patients were detained under the Mental Health (Northern Ireland) Order 1986.

Five patients were on enhanced observations on the day of the inspection. Patients within Killead ward receive input from a multidisciplinary team which incorporates psychiatry, nursing, psychology, behaviour support and social work professionals. A patient advocacy service is also available.

On the days of the inspection, the inspector noted the ward was welcoming. The ward was well lit, well maintained, clean and fresh smelling. The main day area is a large integrated dining / lounge area; there are also four smaller lounge areas available on the ward. Two separate areas of the ward have been converted using three bedrooms in each area into a living, dining and bedroom area for patients requiring bespoke individualised care.

All patients had their own ensuite bedroom which were individualised with patients' personal items. Entry and exit of the ward was unrestricted during the hours of 9am to 6pm, after this time entry and exit is managed by staff.

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 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 Killead ward was undertaken on 24 and 25 November 2014.

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

The recommendations made following the last announced inspection on 20 and 21 January 2014 were evaluated. The inspector noted that eight of the 15 recommendations had been fully met; one recommendation was no longer relevant to the ward and was therefore not assessed and removed. Compliance had been achieved in the following areas:

- Resettlement meetings are held fortnightly with owning trusts; records are maintained in the patients individual care documentation. Patients also have discharge care plans in place. Resettlement of patients is co-ordinated by the hospital resettlement officer.
- Training records for the ward confirmed that all staff were up to date with mandatory training.
- An audit tool had been introduced for the auditing of care records this is undertaken by the acting charge nurse.
- All permanent staff working on the ward had received up to date training in the use of Management of Actual and Potential Aggression (MAPA).
- Minutes of meetings evidenced that advocacy involvement was documented and recorded.
- Patients care records demonstrated that ward staff and hospital management were striving to ensure the efficient discharge of patient's no longer in receipt of active care and treatment.
- All patients had a person centred discharge care plan, this was reviewed six monthly or sooner if required.

However, despite assurances from the Trust, six recommendations had not been fully implemented; all six recommendations 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 patient experience interview inspection

The recommendations made following the patient experience interview inspection on 25th June 2014 were evaluated. The inspector noted that the single recommendation made had been fully met.

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 inspector was pleased to note that all four recommendations had been fully met. RQIA would however suggest that the

current finance policy is amended to reflect purchasing of large items by those patients with or without capacity.

5.0 Inspection Summary

Since the last inspection it was noted that the ward and hospital staff were working proactively to secure a safe and prompt discharge of patients. Ward and hospital staff were considering all options and resources within their remit to ensure that patients were resettled to a community placement appropriate to their individual needs. Evidence of care plans and meetings to help support the work being undertaken were reviewed by the inspector. Since the last inspection 8 of the 15 recommendations had been fully met, one recommendation is no longer relevant and 6 have been restated. The inspector was pleased to observe that staff treated patients with dignity and respect. There was evidence of patient outings and therapeutic activities on the ward, as well as 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 inspector observed therapeutic engagement 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 legislation was available for staff and patients. Patient and/or relative involvement in care was reflective in the care documentation reviewed. Staff confirmed during interview their knowledge on capacity to consent and informed the inspector 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 assess understanding, this included revisiting after a period of time or have another member of staff speak with the patient.

Information in relation to the Human Rights Act was available to guide staff on the ward. Consideration in patients care records was given to patients Human Rights Article 3, 5, 8 and 14. All four ward staff interviewed demonstrated their awareness of patients Human Rights. Capacity, consent and Human Rights awareness was included in the ward induction programme. Not all staff had attended training on capacity, consent and Human Rights, however the inspector was provided with dates of further training for those staff not trained.

Three of the four patient care records reviewed had a holistic individualised assessment of needs completed. Care plans identified the assessed needs of the patient; these were comprehensive and provided an explanation to the identified need. Care plans were reviewed and updated six monthly or sooner if required by the multidisciplinary team. Care plans did not provide reference to the obtaining of consent prior to care being delivered and the actions to

take if consent was not achieved. There was documented evidence in the patients' daily progress notes of patient and family involvement. It was good to note that in the care records reviewed all patients had been consistently consulted with; this was recorded in individual care records along with patient's signatures throughout. Individualised detention care plans were in place for those patients detained under the Mental Health (Northern Ireland) Order 1986.

There was evidence of an individualised care plan in place to support a patient with complex behaviours that challenge. Evidence from care records reflected that the patient's individual needs were identified and supported. Care plans were used to support the higher level of need through the use of person specific tools; this included positive behaviour support plans (Traffic Light System). Tools helped to identify triggers, function of behaviour and proactive strategies. It was positive to note that post incident support and debrief is offered to staff when required.

In one of the patient's files a comprehensive risk screening tool was in place. The tool indicated that there was no need to progress to a comprehensive risk assessment, however a rationale for this decision had not been recorded and had not been signed by the relevant persons. Another patient's file had progressed to a comprehensive risk assessment. In this case the assessment had not been reviewed 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.

All patients had an assessment of their communication needs and a communication passport completed where required. In one of the patients care records it was noted that there had been a sensory integration screening assessment completed. Staff demonstrated their knowledge of patient's communication needs and were familiar with patients' likes, dislikes and choices. There was evidence that where required speech and language therapy involvement had been sought, in relation to setting up communication aids/tools.

Patients had individualised assessments and plans for therapeutic and recreational activity plans. Patients attend day care in Moyola and Portmore. Information was displayed in relation to activities offered on the ward. For those patients who require it, a personalised daily schedule was displayed in their bedrooms. This provided a visual reminder for patients of the activities and schedule for the day ahead. Occupational Therapy (OT) assessments and reports were included in the patients care documentation reviewed, and OT recommendations were included in the care plans. Patients' likes, dislikes and choices were included in the care documentation reviewed.

Easy read information in relation to; the patients charter, how to make a complaint, how to access independent advocacy services, deprivation of liberty, capacity and consent was available for patients, RQIA and Safeguarding Vulnerable Adults. A ward information pack was available for patients and relatives. Staff were familiar with how to access and effectively

utilise advocacy services. Advocacy involvement, were relevant, was documented in the patients care documentation.

Exit and entrance from the ward was open during specific hours, outside of the set times the doors to the ward are locked, exit and access is then managed by staff. A rationale was provided within three of the four patient's individual restrictive practice care plans reviewed. Care plans demonstrated that the restrictions were proportionate to the risk and the least restrictive. Care plans were signed by patients' and/or relatives.

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

The inspector was informed by the acting charge nurse that discharge planning commences on admission in accordance with policy and procedure. Discharge care plans were individualised, detailed and reviewed six monthly. When a community placement is sourced staff accompanies patients during introductions to their new home. Staff from the new facilities visit patients on the ward. The acting charge nurse advised that there were 16 patients on the ward who were delayed in their discharge from hospital. Six of these patients had an identified community placement while eight patients were awaiting a suitable community placement. Resettlement meetings occur fortnightly.

The inspector reviewed a copy of a completed 'All About Me Passport' for a patient who had an identified community placement, this passport aided in enhancing a patient centred approach to transition into the community. The inspectors raised concerns with the resettlement officer, acting charge nurse and hospital management regarding patients with a delayed discharge. Inspectors could evidence that ongoing pro-active work was being undertaken by the hospital to ensure the speedy discharge of patients into an individualised community setting. RQIA therefore agreed to formally address the matter with the Health and Social Care Board.

Details of the above findings are included in Appendix 2.

On this occasion Killead 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	7
Ward Staff	4
Relatives	1
Other Ward Professionals	7
Advocates	1

Patients

Seven patients chose to meet with inspectors. Patients were able to inform inspectors about their daily activities and were able to show inspectors their individual daily schedules. One patient did state that they would like more activities to do on the ward and work-skills. All other patients who spoke to the inspectors 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 “staff are very good to me”, “I really enjoy spending time in my room doing my weaving”. A number of patients did discuss with inspectors anxieties associated with their delayed discharge from hospital. In each case inspectors reassured patients and discussed the matters with the acting charge nurse and the hospital senior management team. RQIA agreed to advocate on behalf of patients in relation to this matter with the Health and Social Care Board.

Relatives/Carers

The inspectors met with one relative. They were complimentary of ward staff stating “staff are more than good”, “I couldn’t do without the staff”. The relative expressed their anxiety regarding delayed discharge. The relative explained that whilst a community placement had not as yet been sourced, they had been kept fully informed and involved in all arrangements to date.

Ward Staff

The inspector met with nursing staff on the ward. Staff stated they were well supported and that ward management were approachable. All nursing staff were complimentary of the acting charge nurse. 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 there was plenty of opportunity for training and development. Staff who spoke with inspectors had no concerns in relation to the ward or patient care; all staff stated that they felt patients on Killead were well cared for.

Other Ward Professionals

The inspectors met with six visiting ward professionals over the course of the two days. All professionals that met with inspectors were able to provide an explanation as to their role and function within the ward. Professionals were also able to provide a summary of their perception of how the ward was performing. All professionals spoke highly of the care delivered on the ward. Visiting professionals expressed concerns regarding the prolonged discharge of many patients. They felt they were exhausting all possibilities within their own remits but that there was a greater issue outside of the hospital.

The inspector 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 were provided with an overview of the 144 substantiated allegations with the DO. The DO advised that there was one ongoing allegation that has now been resolved as the matter was investigated and found to be unsubstantiated. The DO reviewed the high level of referrals; they advised that the increase of referrals had been at a time when a number of patients on the ward were unwell and presenting with an increase of challenging behaviours. The DO informed inspectors that there has been a recent reduction of referrals in the past three months. They advised that referrals for safeguarding investigation by ward staff had been promptly completed and that protection plans were put in place. The DO informed inspectors that incidents had been appropriately reviewed in accordance with the trust safeguarding policy and procedure.

Advocates

The inspector met with one ward advocate. The ward advocate advised that they were invited to ward resettlement meetings for the patients that they represent. The advocate advised they felt able to contribute effectively to patient resettlement planning and care. The advocate advised that they had no concerns regarding care delivered on the ward, however they did feel that the physical environment was not conducive to the patient's needs, particularly due to noise levels on the ward.

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	9
Other Ward Professionals	5	5
Relatives/carers	20	9

Ward Staff

Nine questionnaires were returned by ward staff

The inspector noted that information contained within the staff questionnaires demonstrated all nine staff were aware of the Deprivation of Liberty Safeguards (DOLS) – interim guidance. Eight of the nine staff members had received restrictive practice training and were aware of restrictive practices on the ward. Examples of restrictive practices as reported by staff included "locked ward at certain times" "1:1 observations", and "MAPA". Five of the nine staff members indicated they had received or had a date scheduled for training in the areas of Human Rights and capacity to consent.

Six of the nine staff members, who returned their questionnaires prior to the inspection, stated they had received training on meeting the needs of patients who require support with communication. Staff indicated that patient's communication needs are recorded in their assessment and care plan. It was observed that staff were familiar with patients who had alternative communication needs and responded appropriately and promptly to patients needs. All nine staff members reported that patients had access to therapeutic and recreational activities and that these programmes meet the patient's needs.

Other Ward Professionals

Five questionnaires were returned by ward professionals in advance of the inspection. It was noted that information contained within the professional's questionnaires demonstrated that four of the five professionals were aware of the Deprivation of Liberty Safeguards (DOLS) – interim guidance. Three of the five professionals had received training in restrictive practices. All five professionals indicated they had received training in the areas of human rights and capacity to consent.

Four of the five ward professionals stated they had received training on meeting the needs of patients who require support with communication. All five staff indicated that patient's communication needs are recorded in their assessment and care plan. Professionals 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

Nine relatives returned questionnaires. Relative's comments included:

"We are very pleased with the care, if anything happens regarding my brother we are told about it as soon as possible"

“the staff are really good to him and give him as much attention as they can. I could not do without their help; this has been the best ward he has been in”

“I am pleased with the care my son gets on this ward. He gets on well with all the staff members and looks forwards to returning after his home visit”
“I am content with the care that my son has received”

7.0 Additional matters examined/additional concerns noted

Care records

The inspector reviewed four sets of patient care documentation. Inspectors in each case reviewed the daily progress notes. It was concerning to note that the daily progress of care delivered to patients had not been contemporaneous or documented in detail. Information recorded was limited and did not provided a clear daily evaluation. Progress notes did not evidence that individual patients needs had been met or attended to in accordance with their plan of care. In some cases a single sentence had been entered for a full shift e.g. “remains on level 4 observations”. Daily progress notes were not in keeping with best practice or Nursing and Midwifery Council (NMC) guidelines on Record Keeping, 2009. In two of the patients care records reviewed, inspectors identified information stored pertaining to other patients on the ward, the acting charge nurse was advised of the above concerns.

Transfer of patients

At the commencement of the inspection inspectors were informed that a patient who had been recently transferred from another ward in the hospital, required to be nursed in a self-contained area of Killead. On review of the accommodation the patient had been provided with their own bedroom, sitting room and dining room in a self-contained area. The patient also had a member of staff with them at all times. Inspectors had concerns in relation to the walled partition that was in place, reassurances were provided by hospital management that this was a temporary partition and that structural work was ongoing. Inspectors reviewed the care documentation for this patient. Inspectors could not evidence from the review of records that there had been a planned consultation between the MDT or that agreement had been achieved prior to the patient moving to the self-contained area. The ward doctor and acting charge nurse informed inspectors that they had not been involved in the transfer of the patient to Killead. There was no evidence of restrictive care plans that evidenced a rationale as to why the patient required to be nursed in a self-contained area. There was no evidence of planned consultation with the patient, relatives or advocacy in relation to the move to the contained area. The patient had not been seen by the ward consultant or Behaviour Nurse Specialist since their move to Killead, however inspectors were advised that a referral to behaviour services had been completed.

Complaints

The details of eight complaints were sent to RQIA with the pre-inspection documentation. The inspector reviewed the record of complaints held on the ward and in discussion with the acting charge nurse clarified the details. The acting charge nurse advised that all complaints had been fully investigated and were now resolved. The resolution of complaints is recorded in individual patient files, the local resolution pro-forma had not been completed in each case.

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 recommendations made following the announced inspection on 20 and 21 January 2014

No.	Reference	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1		It is recommended that links between community staff, and hospital staff are developed to ensure that planning and facilitating discharge becomes shared and seamless. **(2)**	Inspectors were informed that resettlement meetings are held fortnightly; records are maintained in the patients individual care documentation. Patients also had discharge care plans in place and meetings for discharge are organised by the host trust. Resettlement of patients is co-ordinated by the hospital resettlement officer.	Fully met
2	17 (4.3)	It is recommended the ward manager ensures all staff working on the ward have received up to date mandatory training.	The inspectors reviewed the training records for the ward and could confirm that all staff were up to date with mandatory training.	Fully met
3	16 (4.3)	It is recommended that the ward manager ensures all comprehensive risk assessments are reviewed in keeping with regional guidelines.	The inspectors reviewed four patients care documentation. In one of the files the patients Comprehensive Risk Assessment (CRA) had no evidence of having been reviewed. In another patients care documentation a risk screening tool was present. This indicated that there was no need to proceed to a CRA, however there was no rationale or signatures in place. The regional Promoting Quality Care Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services May 2010, had not been followed.	Not met
4	16 (2.0)	It is recommended that the ward manager ensures risk assessments are discussed with patients and their representatives	Four sets of patient's care records reviewed evidenced that patients and relatives signatures had been recorded on individual patients risk assessments. Where this had not been included an explanation was recorded.	Fully met

		and this is documented in the care documentation.		
5	17 (5.3.1)(f)	It is recommended the ward manager ensures that staff complete documentation in line with published professional guidance in record keeping.	The inspectors reviewed four set of patients care records. In two of these care records inspectors identified information stored pertaining to other patients on the ward. Inspectors reviewed patient's daily progress notes; inspectors were concerned that comments recorded daily by Registered Nurses did not reflect an evaluation of care delivered to individual patients. Records were not detailed or contemporaneous in keeping with Nursing and Midwifery Council (NMC) Record Keeping guidelines 2010.	Not met
6	17 (5.3.1)(f)	It is recommended the ward manager introduces a system of auditing records and records keeping ensuring defined processes are followed consistently by relevant staff.	The acting charge nurse informed inspectors that an audit tool had been introduced. Samples of completed audits were provided to inspectors.	Fully met
7	6	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.	Inspectors reviewed four sets of care documentation. There was evidence that the Deprivation of Liberty Safeguards (DOLS) – Interim Guidance had been implemented within three of the records sampled. Restrictive practice care plans had been completed and were reviewed regularly for three records. Care plans for three patients demonstrated that restrictions were proportionate to the risk and the least restrictive measure. There was no evidence of care plans in relation to actual or perceived deprivation of liberty in one set of care	Not met

			documentation for a patient who had recently been transferred from another ward within Muckamore. There was no evidence of any Multi-disciplinary discussions and an updated care plan in relation to actual or perceived deprivation of liberty. Inspectors were informed by the acting charge nurse and ward doctor that they were not involved in discussions or decision making in relation to the transfer of this patient.	
8	6	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.	Inspectors reviewed four sets of care documentation; three sets of care records had been reviewed and included evidence of proactive strategies that looked at ways to reduce restrictions. There was no evidence of care plans in relation to actual or perceived deprivation of liberty in one set of care documentation for a patient who had recently been transferred from another ward within Muckamore. There was no evidence of any Multi-disciplinary discussions and an updated care plan in relation to actual or perceived deprivation of liberty. Inspectors were informed by the acting charge nurse and ward doctor that they were not involved in discussions or decision making in relation to the transfer of this patient.	Not met
9	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	Inspectors reviewed four patients care documentation. There was evidence in three files that care plans and risk assessments had been discussed with patients and/or relatives. Care plans in these files had been signed and were a signature was not recorded an explanation was provided.	Not met

		documented in the care documentation.	There was no evidence of care plans in relation to actual or perceived deprivation of liberty in one set of care documentation for a patient who had recently been transferred from another ward within Muckamore. There was no evidence of any Multi-disciplinary discussions and an updated care plan in relation to actual or perceived deprivation of liberty. Inspectors were informed by the acting charge nurse and ward doctor that they were not involved in discussions or decision making in relation to the transfer of this patient.	
10	17 (5.3.3)	It is recommended the ward manager ensures all staff working on the ward have received up to date training in the use of physical intervention.	The inspectors reviewed the ward training records. On review, all permanent staff had received up to date training in the use of Management of Actual and Potential Aggression (MAPA).	Fully met
11	17 (6.3.2)	It is recommended the ward manager ensures any correspondence with advocacy services is clearly documented.	Inspectors reviewed four sets of patient care records. There was evidence from minutes of meetings that advocacy involvement was documented and recorded. Inspectors also spoke with one of the ward advocates, the advocate explained their input into patient care and how this is captured.	Fully met
12	17 (5.3.1)	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.	One of the four sets of patient care records reviewed referenced the needs of a patient with dysphagia. Inspectors reviewed all records relating to this element of comorbidity. On review of the Malnutrition Universal risk Screening Tool (MUST) the patient had been identified as 'at risk'. There had been no review of the assessment since initial completion.	Not met

13	17 (5.3.3) (b)	It is recommended the Belfast trust liaise with patients' host trusts with a view to establishing a link with ward staff, and meet with patients whose discharge has been delayed on a regular basis.	Patients care records demonstrated that ward staff and hospital management were striving to ensure the efficient discharge of patients. RQIA have agreed to escalate this matter to the Health and Social Care Board, given the number of delayed discharges on the ward.	Fully Met
14	17 (5.3.3)(b)	It recommended the ward manager ensures a care plan in relation to discharge is completed for each patient.	Inspectors reviewed care records pertaining to four patients. Inspectors evidenced that all patients had a person centred discharge care plan, this was reviewed six monthly or sooner if required.	Fully met
15	17 (5.3)	It is recommended the ward manager ensures a multi-disciplinary assessment, is completed when a patient may require a specialist piece of equipment. This assessment should include a clear rationale for the decision for purchasing the equipment including what other measures have been considered and discounted and the reason for this.	Recommendation no longer relevant to this ward – recommendation removed.	Not assessed

Appendix 1

Follow-up on recommendations made following the patient experience interview inspection on 25th June 2014

No.	Reference.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	5.3.3	It is recommended the ward manager ensures all patients have access to a quiet area in which to relax during the day.	Killead ward has four quiet rooms available for communal patient use. There is a separate quiet room for visitors just off the ward and also a nearby cafe. Patient's bedrooms remain unlocked at all times unless they choose differently; patients can therefore go to their room independently for quiet time and privacy.	Fully met

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 records in relation to the management of patient monies on the ward. There was a record maintained of staff who access the key to the Bisley drawer, the reason for this access was recorded. A signature list is completed, with staff names, band and signature. The acting charge nurse completes a weekly audit and the operational manager completes a monthly audit.	Fully met
2	It is recommended that the Trust review the policy on payment for use of the leased bus as a matter of urgency to ensure that all patients are charged equitably for its use.	The policy and procedure for use of the hospital bus was available for review and in date. Ward staff complete a request for mobility vehicles as required for recreational and social outings. The acting charge nurse is provided monthly with a copy of patient's individual accounts, this	Fully met

		allows for additional monitoring and auditing of expenditure.	
3	It is recommended that the ward manager ensures that all staff are aware of and receive training in a revised Trust policy for charging for transport.	The acting charge nurse informed inspectors that ward staff are provided with guidance and support regarding the Trust policy. Staff can independently access all trust policies through use of the trust intranet. Inspectors noted documentation in relation to charges for transport was completed in accordance with Trust Policy.	Fully met
4	It is recommended that the Trust devise and implement a policy and procedure for authorising payments to relatives for large purchases, and/or recurrent sums of monies, taking cognisance of the Trust policies and procedures for safeguarding vulnerable adults.	Inspectors reviewed evidence of records for a patient who had made a large purchase for a family member. Information included a best interest checklist and multi-disciplinary meeting minutes. Evidence provided reflected best practice guidance had been followed, in accordance with the remit of the Trust finance and safeguarding vulnerable adult policies. Hospital senior managers also provided reassurances in relation to the above process. RQIA would however suggest that the current finance policy is amended to reflect purchasing of large items by those patients with capacity.	Fully met

Follow up on the implementation of any recommendations made following the investigation of a Serious Adverse Incident

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

Quality Improvement Plan

Unannounced Inspection

Killead Ward, Muckamore Abbey Hospital

24 & 25 November 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 Acting Charge Nurse and other hospital personnel.

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

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
1	5.3.1(a)	It is recommended that the ward manager ensures all comprehensive risk assessments are reviewed in keeping with regional guidelines.	2	27 January 2015	The ward manager will ensure that the on-going monthly audit of risk assessments monitors the review of comprehensive risk assessments in keeping with regional guidelines.
2	5.3.1(f)	It is recommended the ward manager ensures that staff complete documentation in line with published professional guidance on record keeping.	2	Immediate and ongoing	The ward manager carries out a monthly internal audit to monitor care documentation. The audit tool used has been recently reviewed and reflects this recommendation. The independent audit tool has also been reviewed and updated. An independent audit will be completed by February 15. Learning from both these audits is shared with all staff in the ward. Both audits monitor that staff complete documentation in line with published professional guidance on record keeping.
3	5.3.1(a)	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	Immediate and ongoing	Patients with additional needs are fully assessed by the MDT and appropriate referrals to other services made.
4	6.3.2	It is recommended the ward	2	Immediate	The ward manager carries out monthly internal

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
		manager ensures that 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.		and ongoing	audits to monitor care documentation. The audit tool used reflects this recommendation. An independent audit will also be completed in the ward by February 15. Learning from both these audits is shared with all staff in the ward. Both audits address that care planning in relation to actual or perceived deprivation of liberty is reviewed to ensure that the rationale and therapeutic aim is included
5	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.	2	Immediate and ongoing	The ward manager carries out monthly internal audits to monitor care documentation. The audit tool used reflects this recommendation. An independent audit will also be completed in the ward by February 15. Learning from both these audits is shared with all staff in the ward. Both audits address that care planning in relation to actual or perceived deprivation of liberty is reviewed and includes evidence of proactive strategies considered to reduce the restriction.
6	6.3.2	It is recommended that the ward manager ensures care plans in	2	Immediate and	The ward manager carries out monthly internal audits to monitor care documentation. The audit

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
		relation to actual or perceived deprivation of liberty are discussed with patients and their representatives and this is documented in the care documentation.		ongoing	tool used reflects this recommendation. An independent audit will also be completed in the ward by February 15. Learning from both these audits is shared with all staff in the ward. Both audits ensure 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.
7	8.3 (h)	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	Immediate and ongoing	The ward manager carries out monthly internal audits to monitor care documentation. The audit tool used reflects this recommendation. An independent audit will also be completed in the ward by February 15. Learning from both these audits is shared with all staff in the ward. Both audits ensure 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.
8	8.3 (i)	It is recommended that the trust review and amend the current	1	20 March	The Trust's Patients' Finance and Private Property Policy has been reviewed and updated to reflect

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
		Patient Finances and Private Property policy to reflect the process for those patients with or without capacity who wish to make large purchases.		2015	this recommendation.
9	5.3.1 (f)	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	Immediate and ongoing	PARIS (an electronic patient record) has been implemented in the hospital (early January 2015). This is an on-going process. Patients progress notes are now recorded on PARIS by all professions and can be viewed as a continuous record. The monthly internal audit the ward manager carries out will continue to monitor care documentation on PARIS. An independent audit will also be completed in the ward by February 15. Learning from both these audits is shared with all staff in the ward.
10	5.3.1 (a)	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	1	Immediate and ongoing	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 a record

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
		patients assessed as not having capacity to consent to care and treatment.			is completed in the patients assessment of needs as to how the treatment or care is and will be delivered in the patients best interests as per DHSSPS guidance The assessment of capacity to make non-routine or more serious decisions are discussed with the MDT and recorded, in consultation with relevant others i.e. the patient and relatives/carers and advocates, and considering the persons best interest.
11	8.3 (j)	It is recommended that the 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.	1	Immediate and ongoing	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 a record is completed in the patients assessment of needs as to how the treatment or care is and will be delivered in the patients best interests as per

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
					DHSSPS guidance. Patients consent to daily care and treatment is also recorded in the progress notes in PARIS The assessment of capacity to make non-routine or more serious decisions are discussed with the MDT and recorded in the progress notes, in consultation with relevant others i.e. the patient and relatives/carers and advocates, and considering the persons best interest.
12	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 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	1	Immediate and ongoing	The ward manager ensures that the on-going monthly audit of risk assessments monitors that the risk screening tool is completed in full. If a decision is made not to proceed to a full comprehensive risk assessment a clear rationale is recorded on the risk screening tool. This is 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.

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
		2010.			
13	6.3.2 (b)	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 multi-disciplinary team. 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.	1	Immediate and ongoing	The decision to transfer patients is made by the MDT based on patient assessed needs. In the event of a transfer to provide an acute admission bed, the decision is taken as early as possible and discussed with all relevant parties; where possible and clearly documented.
14	8.3 (k)	It is recommended that the ward manager ensures that the local resolution pro-forma is completed and retained upon resolution of a complaint.	1	Immediate and ongoing	The ward manager has set up a dedicated file to facilitate the storage of the pro-forma for local resolution of complaints, in line with Trust policy.

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				Inspector	Date
		Yes	No		
A.	Quality Improvement Plan response assessed by inspector as acceptable	x		Kieran McCormick	**20/01/15**
B.	Further information requested from provider		x	Kieran McCormick	**20/01/15**

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 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 a record is completed in the patients assessment of needs as to how the treatment or care is and will be delivered in the patients best interests as per DHSSPS guidance However, the assessment of capacity to make non-routine or more serious decisions are discussed with the MDT and recorded, in consultation with relevant others i.e. the patient and relatives/carers and advocates, and considering the persons best interest. The section 'About me' provides patient/carer/relative an opportunity to provide information about the patient, including likes/dislikes, wishes/wants and preferences - this section can be taken away for completion in the persons own time. A welcome pack is available on the ward and shared with new admissions and their relatives Easy read documentation is available for patients and families. – i.e. consent, human rights, MHO	Substantially compliant

Relatives are encouraged to be actively involved through open visiting, regular phone calls and invites to MDT meetings. Patients are encouraged to attend the MDT meetings and can request to meet with members of the MD team on other occasions. Patients can also contribute to the meeting verbally prior to it taking place. When appropriate, visits by patients to the family home are encouraged and facilitated Patients have their own bedrooms and ensuite bathroom. A visitors room is provided to facilitate privacy Care plans are person centred and address family involvement Privacy and dignity is addressed through the patients care plan Human Rights Act is available in the ward, all staff are aware of Article 8 and article 14, both are considered in the patients care plan Human rights awareness training is available for staff through TAS Patients' Finances and Private Property – Policy for Inpatients within Mental Health and Learning Disability Hospitals available in the ward	
Inspection Findings: FOR RQIA INSPECTORS USE Only	
The inspectors reviewed care documentation in relation to four of 20 patients and noted the following; • Assessments and care plans were individualised and person centred • staff had discussed care plans with patients • all records reviewed evidenced patient or relatives signatures • there was evidence of family involvement in the completion of care plans were appropriate • relatives were invited to multi-disciplinary and resettlement meetings and their attendance or otherwise noted • outcomes from multi-disciplinary meetings and resettlement meetings were shared with relatives were appropriate • care plans were reviewed and updated six monthly.	Substantially compliant

Inspectors noted there was no reference to patient's capacity to consent for care, treatment or invasive procedures. Care plans did not provide guidance to staff on how to obtain or assess consent on an individual basis or the actions to take if consent was not obtained. The daily progress notes made no reference that patients were involved and/or either agreed or disagreed to care and treatment on a daily basis. It was noted that reference and consideration was given to the patients Human Rights. Four of the 14 ward staff interviewed by the inspectors confirmed their knowledge on capacity to consent and informed the inspectors of the steps they took to ensure the patient consented to care and treatment. This included taking time to explain care to patients or, try again at a different time of the day. Staff informed the inspectors of the actions they took if a patient showed signs that they were not consenting and stated they respected the patients' right to refuse care and treatment. Staff interviewed stated that patients would also initiate or seek staff to assist them with care and treatment tasks, this would also inform staff of the patient's wishes. The policies, procedures and guidance in relation to capacity and consent and Human Rights were included in the staff ward induction programme and were available for review. The acting charge nurse confirmed that six staff nurses from the ward had attended up to date consent and capacity training and that any remaining staff nurses had been booked to attend future dates. The acting charge nurse informed the inspectors that this training was not formally offered to health care assistants. Both healthcare assistants that the inspectors interviewed were well informed and articulated in relation to Capacity and Consent. There were completed assessments for patients' capacity to manage their finances. Training records evidenced staff working on the ward had received up to date training in Human Rights and Deprivation of Liberty. Information in relation to capacity to consent and Human Rights was available for patients and visitors. Easy read information documents were available on the ward, including, the Mental Health (Northern Ireland) Order 1986, Deprivation of Liberty, Human Rights and capacity to consent. The acting charge nurse informed inspectors that easy read documentation is available and is used to provided information to patients' in relation to their care. All nine relative questionnaires returned indicated that they had no concerns about their relatives' capacity to consent.	

Ward Self-Assessment	
Statement 2: Individualised assessment and management of need and risk • **Patients and/or their representatives are involved in holistic needs assessment and in development of related individualised, person-centred care plans and risk management plans** • **Patients with communication needs have their communication needs assessed and there are appropriate arrangements in place to promote the patient's ability to meaningfully engage in the assessment of their needs, planning and agreeing care and treatment plans and in the review of their needs and services.** • **Assessment of need is a continuous process and plans are revised regularly with the involvement of the patient and/or their representative and in accordance with any changes to assessed needs.** • **Patients' Article 8 rights to respect for private and family life have been considered.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
All patients have a person centred care plan, which includes a holistic 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. 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 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 are referred to Speech & Language therapy when required Communication aids are used, if required, following specialist assessments.	Substantially compliant

The Human Rights Act is available in the ward, all staff are aware of Article 8 and Article 14, both are considered in the patients care plan A guide to The Human Rights Act is available in easy read	
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
The inspectors reviewed care documentation in relation to four of the 20 patients on the wards. Each patient had an individualised and holistic assessment of needs. Inspectors reviewed one comprehensive risk screening tool and one comprehensive risk assessment. Inspectors noted they were not completed in accordance with the Promoting Quality Care Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services May 2010. There was no rationale provided as to why there was no progression to a comprehensive risk assessment or review in accordance with the guidance. Three of the four patient care records reviewed reflected care plans addressed assessed needs of the patient. Risk assessments and care plans were reviewed and updated six monthly or sooner if there are changes to the patients' needs. One set of care documentation was incomplete, there was no rationale provided in relation to the restrictions of living in a self-contained area on the ward, there was also no evidence that the least restrictive options had been considered. A Human Rights approach was documented in the care documentation and voiced by staff that were interviewed. Inspectors noted that one patient required support with communication and had a communication passport completed. The communication passport was individualised, detailed and provided clear guidance on how to communicate with the patient and promote meaningful engagement. The four ward staff interviewed demonstrated their knowledge of patients communication needs. Staff were familiar with individual patient needs, their likes, dislikes and choices. The inspectors spoke to seven patients on the ward. All patients indicated they had been involved in their care and treatment plans, multi-disciplinary meetings, one to one time with their primary nurse and consultant psychiatrist. Eight out of the nine relative questionnaires returned stated their family member had been offered the opportunity to be involved in decisions in relation to their care and treatment. One questionnaire returned gave no answer. Eight of the nine relative questionnaires stated they had been offered the opportunity to be	Substantially compliant

involved in decisions regarding their family members' care and treatment.	

Ward Self-Assessment	
Statement 3: Therapeutic & recreational activity • **Patients have the opportunity to be involved in agreeing to and participating in therapeutic and recreational activity programmes relevant to their identified needs. This includes access to off the ward activities.** • **Patients' Article 8 rights to respect for private and family life have been considered.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
Therapeutic and recreational activity is individually assessed through the patients care plan All patients have individualised activity timetables Patients attend day-care on a sessional basis – off the ward. If assessed as a need patients can avail of in reach day-care Patients participate in therapeutic activities on the ward, these include foot spas, table top activities, art work, music therapy, aromatherapy A programme of available activities is on display - this includes recreational and therapeutic activities on and off the ward 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	Substantially compliant
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	

Inspectors completed direct observations of the ward over the two day inspection period. The inspectors observed therapeutic and recreational activities taking place for patients on the ward. This included artwork, playing pool and one to one time. Inspectors noted that patients were offered the opportunity to attend on-site day care and this was included on their weekly activity plan. Inspectors noted in the four sets of care documentation reviewed that patients' recreational and therapeutic needs had been individually assessed and activity plans had been developed. Inspectors noted individualised activity schedules were displayed in the four bedrooms observed. Inspectors observed staff actively engage with patients, communication and interactions were positive. Staff were observed completing enhanced observations with patients, this opportunity was used to engage meaningfully and therapeutically with the patient. Occupational Therapy (OT) assessments and reports were included in the four sets of care documentation reviewed. There was evidence that recommendations made by the OT were implemented and applied to the activity schedules and included patients likes, dislikes and choices. Inspectors noted that there was limited recording in daily progress notes of patient participation in activities and the therapeutic outcome. There was documented evidence that consideration was given to patients' rights to respect for private and family life and all records were completed giving consideration to Human Rights legislation. Inspectors were informed that each patients key worker at Moyola or Portmore complete an individual day care assessment. This is reviewed three monthly by day-care staff, the named nurse also provides a summary of therapeutic outcome and all patients day-care opportunities are reviewed annually. It was positive to note that Dialectal Behaviour Therapy (DBT) and other bespoke therapies were provided to individual patients, evidence reviewed indicated that these therapies were providing a positive outcome for patients. Patients that received DBT informed inspectors of the therapeutic benefit of the therapy. Family and friends visiting Killead are welcome onto the main ward; a private room was available for visits. There was evidence in the patients care documentation of family contact either on the ward or out on pass. Eight of the nine relative questionnaires returned stated their family member had an individualised assessment completed in relation to therapeutic and recreational activities.	Complaint

Ward Self-Assessment	
Statement 4: Information about rights • **Patients have been informed about their rights in a format suitable to their individual needs and access to the communication method of his/her choice. This includes the right to refuse care and treatment, information in relation to detention processes, information about the Mental Health Review Tribunal, referral to the Mental Health Review Tribunal, making a complaint, and access to independent advocacy services.** • **Patients' Article 5 rights to liberty and security of person, Article 8 rights to respect for private and family life and Article 14 right to be free from discrimination have been considered.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
Easy read leaflets and documents are available for patients and for use by staff / family / advocates The patients charter is available in the ward for patients and relatives - easy read An explanation of the MHO is available in the ward A guide to The Human Rights Act is available in easy read Easy read leaflets are available re levels of observation Easy read booklet – 'You, Muckamore Abbey Hospital and the Law' is available Easy read booklet re making a complaint 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	Substantially compliant

Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
The inspectors spoke with seven of 20 patients on the ward. All patients indicated they had been informed of their rights and were aware of who to speak to if they were concerned or wanted to make a complaint. Information on how to make a complaint was displayed in the patient communal area. It was noted that the patient's charter of rights was displayed on the ward. Easy read information was also available for patients and relatives in relation to advocacy services, how to make a complaint, capacity to consent, the Mental Health (Northern Ireland) Order 1986 and patient's rights while in hospital. A ward information pack was also available. Information regarding The Regulation and Quality Improvement Authority and the Mental Health Review Tribunal was displayed throughout the ward. The acting charge nurse and staff were familiar with how to access and effectively utilise advocacy services. Information in relation to the Human Rights Act was available for staff on the ward. The four ward staff interviewed demonstrated their awareness of patients Human Rights; this was reflective during observation of practice on the ward and on review of patients care records. There was evidence of advocacy involvement in the care documentation. Inspectors also met with a visiting advocate during the course of the inspection, the advocate confirmed they visited the ward routinely and confirmed their involvement in MDT and resettlement meetings. Information regarding independent advocacy services was displayed in the patients' communal area. This included the date and time of the advocate visit. In the four sets of care documentation reviewed 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. Inspectors reviewed details of eight complaints that were sent to RQIA with the pre-inspection documentation. Inspectors reviewed the record of complaints held on the ward and in discussion with the acting charge nurse clarified the details. The acting charge nurse advised that all complaints had been fully investigated and were now resolved. The resolution of complaints is recorded in individual patient files; however the local resolution pro-forma had not been completed in each case. Five out of the nine relative questionnaires returned indicated that their family member had been informed of their rights in relation to making a complaint and access to advocacy services. The five relatives also stated they had been informed of the advocacy services available.	Compliant

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

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:	
Monthly MDT resettlement/discharge meetings, for each Trust, take place in the ward - 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. If a placement in the community has not been identified, the named nurse contacts the care manager each month for an update Delayed discharges are reported to the H&SCB The Human Rights Act is available in the ward, all staff are aware of and consider Article 8 through the patients care plan	Substantially compliant
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
The acting charge nurse informed that discharge planning commences upon admission in accordance with trust policy and procedure. The resettlement officer for the hospital, informed inspectors that the care managers	Substantially compliant

from the owning trust organise meetings to discuss plans for discharge and that resettlement meetings occur fortnightly. The inspectors reviewed four patients care records, individualised discharge planning care plans were in place for those patients who were ready for discharge. Discharge care plans were signed by the patient, give consideration to the Human Rights Act and are reviewed six monthly or sooner if necessary. Records evidenced the input of other healthcare professionals such as Occupational Therapist, Speech and Language Therapist or behaviour sciences in the preparation for discharge. A visiting advocate to the ward informed inspectors that she took an active role in the resettlement of the four patients she was working with. The acting charge nurse advised that there were 16 patients on the ward who were delayed in their discharge from hospital. All 16 patients were waiting on moving to placements in the community, six of these patients had an identified community placement, while eight patients were awaiting a suitable community placement that would meet their individual needs. The inspectors reviewed a copy of a completed 'All About Me Passport' for a patient who had an identified community placement, this passport aided in enhancing a patient centred approach to the transition into the community. Inspectors observed patients asking staff when they would be getting "a house", staff were noted to respond efficiently, appropriately and provided reassurances and answers to patients questions. It was evident from discussions with patients, relatives and staff that there was a frustration in the delayed discharge of individual patients. Three of the nine relative questionnaires returned stated their family member had a discharge plan completed, the remaining five questionnaires stated their relative had not, and one questionnaire provided no response to the question. Inspectors were informed that when a community 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 visited patients on the ward, this helped to familiarise the patients and familiarise the new staff about the patients' needs and the care and support they require. The acting charge nurse confirmed that the Health and Social Care Board (HSCB) were informed of delayed discharges monthly. The inspectors raised concerns with the resettlement officer, acting charge nurse and hospital management	

regarding the prolonged delayed discharge of patients. Inspectors could evidence that ongoing pro-active work was being undertaken by the hospital to ensure the speedy discharge of patients into an individualised community setting. RQIA therefore agreed to formally address the matter with the HSCB.	

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

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