The Regulation and Quality Improvement Authority

RQIA

Mental Health & Learning Disability

Announced Inspection

Killead Ward, Muckamore Abbey Hospital

20 & 21 January 2014

Belfast Health & Social Care Trust

npm national preventive mechanism

informing and improving health and social care
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1.0 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).

1.1 Purpose of the Inspection

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

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

- The Mental Health (Northern Ireland) Order 1986;
- 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.

1.2 Methods/Process

Committed to a culture of learning, 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 the previous inspection on **19 and 20 May 2011** were also assessed during this inspection to determine the Trust's progress towards compliance. The inspector found compliance in the following areas,

- Advocacy services were available to all patients
- Patient meetings were held on a regular basis on the ward and outcomes and feedback were raised and clearly recorded for each meeting
- There was a welcome pack available for all patients
- Patients had received induction / orientation information
- Information about daily routines and activities was displayed on the ward
- Nursing care plans for patients detained and patients placed on observation levels had been completed
- Patients were given choice to attend multi-disciplinary ward rounds
- All patients had received an annual review
- The primary nurse had recorded therapeutic time spent with the patient
- The progress notes reflected a daily entry of the patients progress and mental state
- Killead ward is now a male only ward

In spite of assurances from the Trust, several recommendations remained outstanding from the previous inspection. Any previously stated recommendations that were outstanding were added to the Quality Improvement Plan accompanying this report.

An overall summary of the ward's performance against the human rights theme of Protection is in Section 3 and full details of the inspection findings are outlined in Appendix 1.

2.0 Ward Profile

Trust	Belfast Health & Social Care Trust
Name of hospital/facility	Killead Ward, Muckamore Abbey Hospital
Address	1 Abbey Road, Muckamore, BT41 4SH
Telephone number	028 94662845
Person-in-charge on day of inspection	Assumpta Cullinan
Email address	Assumpta.cullinan@belfasttrust.hscni.net
Nature of service - MH/LD	Learning Disability
Name of ward/s and category of care	Killead Treatment
Number of patients and occupancy level on days of inspection	24 beds 22 patients
Number of detained patients on day of inspection	6
Date of last inspection	19 and 20 May 2011
Name of inspector	Wendy McGregor

Killead is twenty four bedded, male treatment 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.
Patients on the ward are transferred from the Cranfield admissions ward following a period of assessment. The inspector was informed there were twenty one patients on the ward on the days of the inspection who have completed a period of assessment and treatment and whose discharge was considered as delayed.

Patients within Killead ward received input from a multidisciplinary team which incorporates psychiatry, nursing, psychology, behaviour support and social work professionals. A patient advocacy service was also available.
The ward shares its spacious entrance and reception area with a neighbouring ward, entry to the ward is not locked.

The ward provides single en suite accommodation for up to twenty four patients.

On the days of the inspection three bedrooms had been converted into a living, dining and bedroom area for a patient.

The main day area is a large integrated dining / lounge and there are some smaller day rooms for patients use.

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

3.0 Inspection Summary

An announced inspection of Killead was undertaken on 20 and 21 January 2014. The purpose of this inspection was to assess the ward's arrangements and procedures for safeguarding vulnerable adults.

The following is a summary of the inspection findings of the arrangements for safeguarding vulnerable adults on this ward and represents the position on the ward on the day of the inspection.

Information relating to adult safeguarding including the Regional Adult Protection Policy and Procedure (2006) and other guidance documents were available on the ward. There was also a flow chart for staff reference displayed in the ward office. Staff interviewed by inspectors confirmed that they had undertaken training and were able to detail actions to be taken in the event of a safeguarding concern.
Review of training records available indicated that all the staff working on the ward on the days of the inspection had undertaken training in safeguarding vulnerable adults.
Records available on the days of the inspection demonstrated that guidance on safeguarding vulnerable adults procedures was included in the induction programme.

All Safeguarding vulnerable adult referrals were forwarded to the Designated Officer (DO) for screening.

The inspector reviewed two vulnerable adult referrals. The safeguarding vulnerable adult policy and procedure was followed. A protection plan was completed in relation to one patient and there was evidence where the referral was discussed at a multi-disciplinary meeting.

A care plan was completed in all four sets of care documentation in relation to each patient's vulnerability on the ward e.g. vulnerability from potential aggression from the other patients on the ward.

There was a system in place to audit safeguarding vulnerable adults and the outcomes were forwarded to the ward manager.

An easy read version of safeguarding vulnerable adult procedures was available in the patient information pack.

One patient interviewed on the day of the inspection made allegations of a safeguarding nature. The patient was subsequently referred as per Belfast Health and Social Care Trust Adult safeguarding procedure and an interim protection plan was completed. The inspector noted the referral and management of the allegation was appropriate.

Four sets of care documentation were reviewed by the inspector.

A Comprehensive Risk Assessment was completed in all four sets of care documentation. The care documentation was individualised. Risks were identified and action plans completed including where relevant Behaviour Support plans to manage the risk. None of the Comprehensive Risk Assessments had been reviewed on the day of the inspection. A recommendation has been made in relation to this.
Evidence of patient involvement was not consistent in the four sets of care documentation or a rationale given where the patient was not involved. A recommendation has been made in relation to this.
Staff signatures were not consistent in the care documentation reviewed by the inspector. A recommendation has been made in relation to this.
There was no formal mechanism in place for the audit of patient care documentation. A recommendation has been made in relation to this.

The inspector noted a number of practices used on the ward that could be viewed as restrictive, e.g. observations levels, the occasional need to lock the entry, exit door, and alarms on bedroom doors. The door to the garden is area is locked as it is an electronic door and cannot be left open. The inspector was informed staff open the door any time a patient requests it.

In the four sets of care documentation reviewed by the inspector it was noted that restrictive care plans had been completed, and these were individualised. Each restriction was documented, however the rationale and therapeutic aim was not consistently recorded in the care documentation reviewed. A recommendation has been made in relation to this.
There was no evidence of a proactive approach for some restrictions e.g. one patient's bedroom door was locked during the day, the rationale for the restriction was given; however, there was no evidence of any proactive strategies considered to reduce this restriction. A recommendation has been made in relation to this.
The potential impact on the patient's human rights had been considered and was clearly documented for each restriction.
There was no evidence of patient or carer involvement or otherwise in the completion of the care plans in relation to restrictive practices. A recommendation has been made in relation to this.
There were a number of patients on enhanced levels of observations. The inspector reviewed two sets of care documentation in relation to this; the rationale had been documented and agreed with medical staff. Daily monitoring forms had been completed.
At times physical intervention is used on the ward; the inspector reviewed one completed physical intervention form and noted it had been completed as per policy and procedure. An incident from had also been completed. The inspector was informed that all physical intervention forms were audited by the Management of Actual and Potential Aggression (MAPA) team. The ward manager was informed of the outcomes of the audit.
Three of forty three staff working on the ward on the day of the inspection had not received up to date training in the use of physical intervention. A recommendation has been made in relation to this.
Therapeutic and recreational activities were available for patients on the days of the inspection.

Activity schedules were included in the four sets of documentation reviewed by the inspector.
Easy read daily activity schedules was evident in the patient's bedrooms.
Most patients avail of five session of day care per week.
Ward based activity schedules were displayed in the patient communal areas for patients not attending day care.
On the days of the inspection the inspector observed two patients being supported by staff to cook their lunch.
All patients who spoke with the inspector stated they got time of the ward, to attend day care, go swimming, cinema, bowling, walks and shopping.
Inspector spoke to the behaviour nurse therapist, who provides 1:1 therapy sessions to some patients who have been assessed as requiring a psychological therapy.

The policy and procedure for patients private property was available to staff on the day of the inspection.
In the four sets of care documentation reviewed by the inspector all patients had an assessment completed by the consultant psychiatrist in relation to their capacity to manage their financial affairs.
Each patient had a locked separate drawer for their money in the ward office.
Records were reviewed by the inspector. Transactions were signed by two staff and the patients were possible. There was evidence of receipts for expenditure.
Documentation was reviewed in relation to audit of the patient's cash drawers and there was evidence that cash drawers are checked daily by two members of staff, weekly by the ward manager and monthly by the senior nurse manager.
A list of patients' property was listed in the four sets of care documentation reviewed during the inspection.
Supervision, Professional Contribution Plans (PDP), Knowledge Skills Framework (KSF) and training records were available on the ward. All staff on the ward had received up to date supervision, PDP and KSF. This was also indicated in the returned staff questionnaires and staff interviewed on the day of the inspection. Staff stated they felt very well supported. Staff also stated they had attended additional training in the use of communication passports.
The training records reviewed by the inspector evidenced that not all mandatory training was up to date. A recommendation has made in relation to this.
There are a number of new staff on the ward, who have not received a corporate induction, as the date they commenced employment was after the last corporate induction date, the next date for corporate induction is March 2014.

Minutes of staff ward meetings were available on the ward. The last staff meeting was in January 2014 and a schedule was noted for 2014 staff meetings.

An organisational structure for the ward was on display in the ward office at the time of the inspection. The patients and staff who met with inspectors on

the day of the inspection were aware of the organisational structure for the ward.

Staff interviewed demonstrated their knowledge of reporting procedures in relation safeguarding vulnerable adults, complaints, incidents and accidents. Information relating to who was on duty was displayed on the ward, this information included photographs of all the staff.

Care notes reviewed by the inspector evidenced that patients who were detained in accordance with Mental Health (Northern Ireland) Order 1986 had been informed of their rights. The information was available in easy read format.

Details in relation to how to make a complaint was displayed on the ward. The information was also available in easy read format.

The ward welcome pack includes easy to read information for patients including 'You, Muckamore Abbey and the Law', 'Your Right to Confidentiality', Keep me safe, treat me with respect'.

The complaints policy and procedure was available for staff.

Complaints and compliments records were reviewed and evidenced one local resolution complaint, which had been resolved. There was also evidence of a number of compliments. The inspector was informed there have been no formal complaints. The inspector was informed compliments and complaints are discussed at monthly unit meetings with the operational manager and learning was shared with other facilities on the hospital site.

The inspector reviewed care documentation in relation to four patients. Assessments were comprehensive and detailed, however not every assessed need had a care intervention completed. A recommendation has been made in relation to this. The care plans were written in an individualised and person centred manner.

Multi-disciplinary referrals were evident, where assessed needs required it e.g. a number of patients had been referred to Speech and Language for swallowing difficulties and had dysphagia guidelines had been completed and included in the patients care plan.

There was one patient on the ward who was displaying signs of dementia. There was no evidence of a dementia specific assessment, although the need for this was documented to by the multi-disciplinary team. A recommendation has been made in relation to this.

There was evidence of one discharge care plan in the four sets of care documentation. A recommendation has been made in relation to this.

The policy in relation to reporting accidents / incidents and serious adverse incidents was available on the ward. The inspector review documentation completed in relation to reporting an incident.

Incidents were reported via DATIX system.

Incidents were audited by the hospital management team and the information made available to the ward manager.

On this occasion Killead ward has achieved an overall compliance level of substantially compliant in relation to the human rights inspection theme “Protection”.

Inspectors would like to thank the patients, staff, relatives and visiting professionals for their cooperation throughout the inspection process.

4.0 Follow-up on Previous Issues

No.	Reference	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	Advocacy services are available to all patients.	It is recommended that the independent advocacy service attend patients meetings on the ward.	The inspector spoke with an independent advocate who confirmed they attended patient meetings where appropriate.	Fully met
2	Patients are informed and familiarised with the comments and complaints process.	It is recommended that patient meetings are held on a regular basis and are promoted on the ward. It is recommended that outcomes and feedback regarding the issues raised are clearly recorded for each meeting.	The inspector reviewed evidence that patient meetings happen every two months. The outcomes and feedback regarding issues raised was clearly recorded.	Fully met

3	Patients are informed and familiarised with the ward environment and routines in an ongoing patient focused manner.	It is recommended that the welcome pack is used for any new admissions to the ward. It is recommended that it is clearly documented when patient receive induction/orientation information. It is recommended that information about the daily routines and activities of the ward are displayed and promoted in the ward.	The inspector reviewed the welcome pack available for all admissions to the ward. In the four sets of care documentation reviewed it was clearly recorded where the patients had received induction / orientation information. The inspector noted information about daily routines and activities was displayed and promoted on the ward.	Fully met
4	All patients are informed of and involved in a person centred assessment and care planning process.	It is recommended that nursing care plans for patients detained in hospital and patients placed on observation levels are completed when appropriate.	The inspector noted nursing care plans had completed for patients detained in hospital and for patients placed on enhanced observations.	Fully met
5	There will be weekly multi-disciplinary team review with patient involvement and appropriate representation from advocates and other relevant agencies	It is recommended that patients are given a choice to attend multidisciplinary ward rounds. It is recommended that the documentation to record the multi-disciplinary team meeting is reviewed to ensure it captures all relevant information,	The inspector noted in the care documentation reviewed that patients had been given the choice to attend their multidisciplinary ward round. Documentation to record the multidisciplinary team meetings was reviewed in relation to four patients	Fully met

	involved in the patient's care.	patient's/relatives views, and records when the patient receives feedback from the meeting. It is recommended that a decision is made regarding the need for yearly review and this is communicated with all staff in a timely manner.	and included patients/relatives views, and when patient receives feedback from the meeting, however the documentation was not fully completed by the multidisciplinary team. A new recommendation has been completed in relation to this The inspector reviewed evidence that yearly reviews have completed.	
6	Patients will be given the opportunity to meet and discuss in private any issues with their primary nurse or in their absence an allocated nurse on a daily basis.	It is recommended that the primary nurse clearly records when they have spent therapeutic time with the patients.	There was evidence in the four sets of care documentation of therapeutic time spent with the patients by their primary nurse.	Fully met
7	The discharge plan should be initiated at the earliest opportunity following admission.	It is recommended that links between community staff and hospital staff are developed to ensure that planning and facilitating discharge becomes shared and seamless. It is recommended that the circumstances surrounding the breakdown of discharge for one of the patients interviewed during the inspection is	There was some evidence of links between community teams; however this was not consistent for all patients. There was inconsistency in the completion of discharge plans completed in the four sets of care documentation reviewed by the	Partially met

		reviewed, and alternative plans in keeping with the patient's current wishes are considered.	inspector. The patient has been discharged from the ward.	
8	Clear documented systems are in place for the management and filing of records in accordance with professional and legislative requirements.	It is recommended that progress notes reflect a daily entry of the patient's progress and mental state.	The daily progress notes reviewed by the inspector included an entry of the patient's progress and mental state.	Fully met
9	Mixed gender ward	It is recommended that the gender mix within the ward continues to be reviewed and patient's views are continually monitored in respect of this.	Killead is now a male treatment ward.	Fully met
10	Ward acoustic	It is recommended that the ward continues to seek a solution to the amplified sounds which occur on the ward.	The ward has brought in outside agencies to seek a solution to the amplified sounds which occur on the ward to date this has been unsuccessful.	Fully met

5.0 Stakeholder Engagement

Questionnaires were issued to staff, patients, relatives/carers and visiting professionals in advance of the inspection. The responses from the questionnaires were used to inform the inspection process.

Questionnaires issued to	Number issued	Number returned
Staff	**25**	**9**

During the inspection the inspector has the opportunity to meet with staff, patients, relatives/carers, visiting professionals or advocates. Below are the details of the number of discussions held during the inspection.

Additional discussions during inspection	Number
Patients	**6**
Carers/Relatives	**1**
Visiting Professionals	**3**
Staff	**2**
Advocates	**3**

The following information is a summary of feedback received from those who returned a questionnaire or met with an inspector during the inspection.

Patients: Six patients were spoken to during the inspection. In summary the patients stated they were generally happy with the care on the ward.
All patients expressed their frustration in relation to the delay in their discharge. Patients raised concerns in relation to the high level of noise on the ward. A safeguarding vulnerable adult referral was completed following a concern raised by one patient.

Carers/ Relatives: The inspector met with one relative. The relative stated they were happy with the care their son received. The relative commented on the support they received and stated they “couldn’t do without the staff” and “it was one less worry knowing her son was well looked after”. The relative confirmed they knew how to raise a complaint. The relative expressed concern in relation to the process of resettling their son into a community setting and the length of time this was taking.

Visiting professionals: Three visiting professionals were spoken to during the inspection. There were no concerns raised about the ward in general. However professionals did express their concern in relation to the number of “delayed discharges”.

Staff: From discussions with staff and the questionnaires received, the staff working on Killead felt well supported. Staff also stated they had been supported to undertake training and develop their skill in relation to their role.

Advocates: The inspector spoke to advocates from two organisations. The information given from the the organisations was not consistent. One advocate stated she was satisfied with the level of engagement on the ward. The advocate stated they attend patient forum meetings, yearly reviews and resettlement meetings. Advocates from the second organisation indicated they were dissatisfied with the level of engagement, and stated they were not always informed and invited to relevant meetings. A recommendation has been made in relation to this.
Both advocates stated they were concerned in relation to the number of delayed discharges on the ward.

6.0 Additional Concerns Noted by Inspectors

There were a number of additional concerns noted by the inspector on the days of the inspection.
Killead is a treatment ward. The inspector was informed by staff that there were a number of patients whose discharged was delayed (21 out of 22 patients). Thus the ward is not in a position to fulfil the function it is commissioned for. Staff also report this had implications for other wards on the Muckamore site.

Supporting patients on Killead ward can be challenging as they have a range of complex physical and mental health issues and display a number of challenging behaviours. Patients on Killead expressed their added anxiety of waiting to be resettled back into community. Some patients had returned to the Killead after their resettlement was not successful. Staff also explained that is difficult to reassure patients who ask them consistently about their resettlement, as they often have no new information to give to the patient. A recommendation has been made in relation to this.

There was one patient who was displaying signs and symptoms of dementia, but has not been formally diagnosed. A recommendation has been made in relation to this.

The inspector noted the use of a “safe space” system with one patient. The inspector was informed the patient sleeps in the “safe space” during the night. The inspector reviewed the patients care documentation. There was limited evidence of multi-disciplinary assessments, details of the multi-disciplinary team involved in the decision making process, other measures considered and a clear rationale as to why these were discounted. The inspector was informed by the ward manager and the patients named nurses that the patients sleep had improved; however there was no documented evidence of this. A recommendation has been made in relation to this.

7.0 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.

8.0 Summary of Compliance – RQIA Assessment

No.	Question	Compliant	Substantially Compliant moving Towards Compliance	Not Compliant	Unlikely to become compliant	Not Applicable
1	The ward has robust arrangements in place that ensure the safety and well-being of patients that are consistent with legislative and best practice guidance documents.	✓				
2	Patients' needs are accurately assessed, risks identified and responded to appropriately.			✓		
3	The ward safeguards patient rights in relation to the use of: (i) restrictive practice; (ii) isolation/seclusion; (iii) close observation; (iv) use of restraint			✓		
4	The ward provides patients with an appropriate range of therapeutic individualised and group activities.	✓				
5	The ward has robust processes in place to ensure the safety of patients' monies and property.	✓				
6	There are procedures in place for the effective management, support, supervision and training of staff.		✓			
7	There is an appropriate organisational structure for the ward that defines staff and management roles, responsibilities and the accountability arrangements.	✓				
8	Patients and their family/carers have access to appropriate information in relation to their rights, including information on how to make a complaint.	✓				
9	Care plans are written in an individualised and person-centred manner that is consistent with professional and legislative requirements.		✓			
10	Staff report accidents, incidents and serious adverse incidents in accordance with policies and procedures and regional guidance and follow these up appropriately.	✓				

Inspection Standards – The organisation has appropriately trained staff and robust procedures to support and meet the needs of patients Ward Self-Assessment	
Statement 1. – **The ward has robust arrangements in place that ensure the safety and well-being of patients/ that are consistent with legislative and best practice guidance documents;** **The ward monitors these arrangements to ensure that they are appropriately and consistently applied;** **Staff ensure that vulnerable adult procedures are followed and all vulnerable adult issues are addressed promptly, appropriately and in accordance with local and regional policies and procedures.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
Killead has a team of 43 staff; Staffing levels are reviewed to ensure the safety of patients and staff. Staffing Rotas are drafted 2 weeks in advance to allow for Senior Nurse Mangers and Ward Sister to review weekly and when necessary clarify if applicable – i.e. Patients attending Outpatients appointments/resettlement visits. All staffing deficits are discussed with Senior Nurse Manager. All patients have a Person Centred Care Plan reflecting their present needs and care. All patients have a risk screening tool and if indicated a comprehensive risk assessment is completed and reviewed in conjunction with the MDT. The BHSCT vulnerable adult process is adhered to. All incidents are referred to the designated vulnerable adult officer and necessary documentation completed - ASP1 form, incident reports completed and NOK updated. Protection plans if deemed necessary are put in place in consultation with the DVAO following any incident to safeguard patients. Medical staff are requested to physical examine the patient, if necessary. Safeguarding Vulnerable Adult training is provided for staff .Staff adhere to the trusts Adult Protection Policy and Procedure. Staff are aware of policies that are relevant to ensure the safety and well being of patients e.g. levels of observations/ whistle blowing /restrictive practice /physical intervention/ zero tolerance/ accident incident reporting and complaints policy .Staff are aware of the Deprivation of Liberty 2010 interim guidance and adhere to their recommendations. All staff receive an induction to the ward and attend mandatory training when necessary. At ward level staff are communicated updated information on vulnerable adult procedures with the use of emails/ face to face meetings / supervision etc. Patients forums are held regularly and points of concern are raised further with Named Nurse and thereafter with Ward	Substantially Compliant

Sister. Patients are also provided with information regarding making a complaint or escalating their concerns for further investigation	
Inspection Findings: FOR RQIA INSPECTORS USE Only	

Inspection Standards – Assessment of need and risk Ward Self-Assessment	
Statement 2. – **Patients' needs are accurately assessed, risks identified and responded to appropriately.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
All patients have a Person Centred Care Plan which identifies their needs and planned interventions. These plans are reviewed by the named nurse. Patients and NOK (if applicable) are involved in their care plan. All patients have a risk screening tool and a comprehensive risk assessment if needed; these are completed and reviewed by the MDT. The vulnerable adult process is adhered to, ASP1 forms are completed for all incidents and forwarded to the DVAO for investigation . The DVAO visits the ward and discusses incidents with staff and patients. Patients are aware of the vulnerable adult process an EASY READ version is available for them. All staff are aware of vulnerable adult procedures and attend mandatory training with regards to same. Staff Nurses also attend Promoting Quality Care training which is necessary to complete comprehensive risk assessments. Patients can be referred to Advocacy services if they wish. Advocates are invited to patient meeting if the patient wishes. All patients have an annual review which, community staff, and family are invited to. All incidents are reported via the DATIX system and incidents are investigated by the ward sister or the deputy charge nurse. Killead is an open ward and the front door remains open from the hours of 9am to 5pm (winter months) and 9am to 7pm (Summer months). A protocol is in place in the event of the door being locked during these hours. A number of Killead patients have been identified for community resettlement. In-reach community staff working with the identified patients receive an induction. Patients who are on the delayed Discharge List or Primary target List – Relevant community personnel are invited to attend the MDT meeting a minimum of 6 monthly to discuss proposed community placement and/or to discuss what stage in the resettlement process each individual has reached.	Substantially Compliant

All patients are reviewed fortnightly All patients have an annual physical examination including bloods	
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	

Inspection Standards – Awareness and application of safeguarding procedures

Ward Self-Assessment

Statement 3 . –The ward safeguards patient rights in relation to the use of: **(i) Restrictive Practice;** **(ii) Isolation/Seclusion;** **(iii) Close Observation;** **(iv) Use of Restraint.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
Patients care plans indicate restrictive practice and the reasons for same .Restrictive practice is reviewed fortnightly at the MDT meeting with a view to reduce the necessary restriction. Restrictions are discussed with patients and their families (if applicable). Patient risk assessments and care plan reflect any restrictions. Deprivation of liberty interim guidance 2010 is available on the ward and easy read information is available for patients. Seclusion is not available in Killead ward. If a patient requires seclusion, they are transferred to ICU. One patient in Killead is nursed in a separate area supervised by two staff members. The decision was taken following consultation with hospital management and the MDT due the significant risk posed to himself and others. Levels of observation are prescribed by the ward consultant to safeguard the patient or others; these are reviewed by the MDT. Levels of observation are discussed with patients and their families (if applicable), this is documented in their care plan. Physical intervention is used as a last resort, using the least restrictive hold. The" let go to calm" approach is implemented. Physical interventions is used as a last resort as per trust policy. Audit forms are completed after physical intervention is completed and are audited by the MAPA team. Body charts are completed as soon as possible after incidents of physical intervention. The trust has governance arrangements in place to monitor and review the use of seclusion and MAPA and identify trends. These reports are shared with staff and available on the ward. Staff trained in MAPA receive an initial five day course followed by a yearly update. Policies on restrictive practice, levels of observation, physical intervention and seclusion are available on the ward.	Substantially compliant
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	

Inspection Standards – Provision of and access to therapeutic activity

Ward Self-Assessment

Statement 4. – **The ward provides patients with an appropriate range of therapeutic individualised and group activities;** **The daily programme with details of professionals involved is available and accessible;** **Clear and accurate documentation is maintained.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
Therapeutic activities are available to all patients, both individual and group. Patients can choose what activities they want to partake in. Daycare is available off the ward for patients. Each patient has their own activity schedule. Cookery sessions are available in the lifeskills room on the ward. A weekly swimming session is also available. Many patients enjoy playing pool and three of the patients are members of the hospital pool team and take part in competitions off site. A weekly evening activity is held in the hospital e.g. disco, games and cinema. Patients attend community functions e.g. concerts, football matches. Patients have the opportunity to shop in their local town and have meals out in restaurants. Two patients have weekly DBT with psychology staff. A high proportion of staff in Killead have attended HABIT training. This consisted three day workshop provided by the clinical education centre which focus on how an individual's behaviour can impact on others within the environment. It also focused on the development and implementation of a HABIT plan for some of the more challenging patients in Killead. Two staff members have recently completed the WRAP training, also provided by the clinical education centre. One patient in Killead has developed their own WRAP plan with staff support which explores and offers methods to keep the person well. Patients can also avail of the Music Therapist, Art therapist, O.T., Advocates and Psychology	Substantially compliant
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	

Inspection Standards – The organisation operates effective procedures for managing patients' finances and property Ward Self-Assessment	
Statement 5. – **The ward has robust processes in place to ensure the safety of patients' monies and property.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
The policy for patients' private property for long stay patients /clients is available on the ward all staff adhere to these procedures. All patients have individual cash drawers and private property drawers. All cash transactions are signed by two staff if the patient is deemed not capable. Receipts are obtained for all expenditures. Patients capacity to manage their finances is assessed by the ward consultant and a financial control form is retained in the patients clinical file, this is also recorded in the patients careplan Some patients have their own individual bedroom key and may keep valuables in their own room The cash office in the hospital is aware of the patients capability in relation to their finances. Cash drawers are checked daily by two staff, weekly by the ward sister or deputy and monthly audits are carried out by the SNM All patients clothing is marked with their name	Substantially Compliant
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	

Inspection Standards – There are procedures in place for the effective management, support, supervision and training of staff. Ward Self-Assessment	
Statement 6. – **The ward has an appropriate training and development plan in place to address the training needs of all staff ;** **Records of training evidence that all staff have attended mandatory training in accordance with policies, and training plans;** **Staff have the necessary skills knowledge and competence for the role they undertake;** **All staff have formally recorded supervision meetings in accordance with policies and procedures;** **All staff have formally recorded annual performance appraisal meetings;** **Additional support is provided for staff through various mechanisms, such as regular ward meetings.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
Personal Contribution Plans are completed annually for all staff; Clinical supervision is completed twice annually for trained staff. There is a high level of peer support within the nursing team. The Senior Nurse Manager makes himself available to all members of the staff and helps to promote a professional working environment. Senior Nurse Manager meets regularly with the Ward Sister to discuss all aspects of developing the ward. A unit meeting takes place monthly and is chaired by the SNM. The Multi Disciplinary Team is readily available to offer support and guidance to all the staff. Training needs are identified by the ward sister, courses are sourced though the hospital NDL. At present one staff is completing a university course and a healthcare assistant is completing a certificate in working in the health sector Level 3. Trained staff support the healthcare assistants in their care group and report any issues to the ward sister. Individual Training records are held on the ward for each staff, these are reviewed to ensure mandatory training is up to date. Staff are aware of their job descriptions. Monthly training records are forwarded to N.D.L. for auditing. Staff have received training in KSF The Trusts core value of learning and development is promoted in the ward Courses are booked through T.A.S. and/or the Beeches.	Substantially compliant

Ward meetings take place on a regular basis where staff have the opportunity to discuss relevant issues or areas of concern. Minutes of same retained on Ward and shared with Senior Nurse Manager. The Ward utilises the Named Nurse concept and support is given throughout by Ward Sister and Deputy Charge Nurse.	
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	

Inspection Standards – There is an appropriate organisational structure for the ward that defines staff and management roles, responsibilities and the accountability arrangements Ward Self-Assessment	
Statement 7. – **Patients and staff are aware of the organisational structure and accountability arrangements;** **Staff can describe their reporting procedures;** **Senior staff can describe their role in the accountability framework for the ward, and how/if this works in practice.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
All staff are aware of their personal and professional accountability. The ward adheres to the BHSCT core value of accountability. Staff are accountable for their own actions. Staff on duty is displayed on the ward notice board. Trained staff are accountable to the NMC and adhere to the 'code of conduct', they are also accountable for maintaining their professional portfolio. Staff roles and responsibilities are outlined in their job description. The overall responsibility of the ward lies with the ward sister. The hospital management structure is displayed on ward notice board. Trust policies and procedures are adhered to by staff in relation to reporting and is included in the ward induction. All newly qualified staff complete Preceptorship training as identified by the BHSCT and must attend corporate Induction day and relevant training (Mandatory). Medical accountability lies with the Consultant Psychiatrist who has overall responsibility for patient care Qualified staff have responsibilities in relation to mandatory and Preceptorship inductions. Qualified staff have specific areas of responsibility within the ward team.	Substantially compliant

All staff are accountable to the patient and the employer.	
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	

Inspection Standards – Information for patients and carers Ward Self-Assessment	
Statement 8. – **Patients and their family/carers have access to appropriate information in relation to their rights;** **There is a defined complaints procedure in place in a format appropriate to the needs of patients and their carers;** **The ward maintains appropriate records of complaints, concerns, suggestions and compliments.** **There is evidence of feedback from the Governance leads in relation to complaints and concerns raised.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
Patients are given an information pack when they transfer to Killead, this pack contains easy read information on their rights, and how to make a complaint. Patients who are detained receive a statement of their rights, which staff explain to them. Leaflets are available on the ward for families and relatives. All complaints are dealt with as per BHSCT policy, and if there is a complaint or a concern, staff try and resolve these through local resolution. All patients have access to Advocacy service – Advocates are invited to attend relevant meetings in relation to proposed community placements, discharge plans and/or at the request of the patient any such meetings – they are also invited to attend patient forums. Patients can use the patients council and the TILII group, which Killead have a patient representative to voice any concerns. Complaints' training is available for all staff. All patients are encouraged to use advocacy services. Named nurses have 1:1 therapeutic sessions with their patients weekly. Patients are involved in their care planning and requests to meet members of the MDT are facilitated. The foyer of the ward has an information screen for patients and relatives.	Substantially compliant
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	

Inspection Standards – The organisation has a clear policy for documentation and management of records, confidentiality and sharing of information. Ward Self-Assessment	
Statement 9 – **Care plans are written in an individualised and person-centred manner that is consistent with professional and legislative requirements.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
All patients have a Person Centred Care Plan which reflect current treatment and planned interventions. All staff adhere to Records Management and confidentiality Policy. Trained staff adhere to N.M.C. guidelines and Code of Conduct re Record keeping. Daily entries are made into all Care Plans. All patients have a Named Nurse who is responsible for their individualised and person-centred care plan All patient care is discussed at the Multi Disciplinary Team meeting (fortnightly) where possible patients are involved in the drawing up of their Care Plan and their reviews Care plans are individual and consideration is given regards restrictive practice on an individual basis depending on Risk – this is discussed with the patient and is shared and agreed by Multi Disciplinary Team and reviewed fortnightly. All Care Plans reflect the Adult Safeguarding process Multi Disciplinary Team reviews Human Rights consideration and restrictive practice. Careplans are stored in a fireproof filing cabinet.	Substantially compliant
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	

Inspection Standards – The organisation has a clear policy for the reporting of accidents, incidents and serious adverse incidents Ward Self-Assessment	
Statement 10. – **Staff report accidents, incidents and serious adverse incidents in accordance with policies and procedures and regional guidance and follow up these up appropriately.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
Staff adhere to BHSCT Policy in relation to reporting accidents /incidents and serious adverse incidents. All incidents are reported via DATIX system. – Approval is sanctioned by Ward Sister / Deputy Charge Nurse, within the set time frame Serious adverse incident are reported immediately to Senior Nurse Manager, Ward Consultant and R.Q.I.A. All incident reports are audited by Hospital Management Team All incidents are recorded in the patients care plan and discussed with the MDT Monthly Incident reports are available at Ward Level for learning Training is available on Adverse Incident Reporting.	Substantially Compliant
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	

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
	Inspector to complete

SUPPLEMENTARY INFORMATION

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

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

Within the last 12 months, please confirm the number of investigations undertaken on the ward and their outcomes.			
Adult Protection Investigations		**Child Protection Investigations**	
Substantiated Allegations	86	Substantiated Allegations	
Unsubstantiated Allegations		Unsubstantiated Allegations	
On-going Allegations	2	On-going Allegations	
Total		Total	

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

These statistics are from April 2013

Quality Improvement Plan

Announced Inspection

Killead Ward, Muckamore Abbey Hospital

20 & 21 January 2014

The issue(s) identified during this inspection are detailed in the inspection report and the Quality Improvement Plan.

The details of the Quality Improvement Plan were discussed with the ward manager and services manager either during or after the inspection visit. Please refer to Appendix 1 for specific reference documents. The timescales for completion commence from the date of the inspection.

1. Recommendations restated from previous inspection

No.	Recommendation	Number of times stated	Details of action to be taken by ward/trust	Timescale
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	The Belfast Trust has agreement in place with host Trusts that a named Care Manager is in place for patients. The care manager is invited to regular meetings to update the MDT and the patient.	**Immediate and on-going**

2. Recommendations made following inspection of safeguarding vulnerable adults and children – human rights theme of protection

No.	Recommendations	Number of times stated	Document Number	Reference	Details of action to be taken by ward/trust	Timescale
	The organisation has appropriately trained staff and robust procedures to support and meet the needs of patients					
2	It is recommended the ward manager ensures all staff working on the ward have received up to date mandatory training.	1	17	4.3	One staff, who took up post in December 2013, is scheduled to complete the 2 week band 3 Trust induction from 18th – 28th March 2014. Three staff, who took up post in December 2013, did not have MAPA at the time of the inspection, two of these staff completed their training in February, the other staff is scheduled to complete the training from 31st March – 4th April 2014	**21st April 2014**
	Assessment of need and risk					

No.	Recommendations	Number of times stated	Document Number	Reference	Details of action to be taken by ward/trust	Timescale
3	It is recommended that the ward manager ensures all comprehensive risk assessments are reviewed in keeping with regional guidelines.	1	16	4.3	MDT meetings have been arranged to review comprehensive risk assessments in keeping with regional guidance	**Immediate and on-going**
4	It is recommended that the ward manager ensures risk assessments are discussed with patients and their representatives and this is documented in the care documentation.	1	16	2.0	Named Nurses are meeting with patients and their representatives to discuss the comprehensive risk assessment. Following this the patient and their representative can sign the risk assessment.	**Immediate and on-going**
5	It is recommended the ward manager ensures that staff complete documentation in line with published professional guidance in record keeping.	1	17	5.3.1 (f)	The ward manager has introduced a system to audit the nursing care plans to ensure that staff complete documentation in line with published professional guidance in record keeping. This is a monthly audit	**Immediate and on-going**
6	It is recommended the ward manager introduces a system of auditing records and records keeping ensuring defined processes are followed consistently by	1	17	5.3.1 (f)	The ward manager has introduced a system to audit the nursing care plans to ensure defined processes	**21 April 2014**

No.	Recommendations	Number of times stated	Document Number	Reference	Details of action to be taken by ward/trust	Timescale
	relevant staff.				are followed consistently by staff. This is a weekly audit with two care plans audited each week.	
	Awareness and application of safeguarding procedures					
7	It is recommended the ward manager ensures that 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.	1	6		The care plans have been updated to reflect the rationale and therapeutic aim is included in relation to actual or perceived deprivation of liberty	**21 April 2014**
8	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.	1	6		Named Nurses are reviewing the patients actual or perceived deprivation of liberty with a view to proactively intervening to reduce restrictions. This is also discussed with the MDT.	**21 April 2014**
9	It is recommended that the ward manager ensures care plans in relation to actual or perceived deprivation of liberty are discussed with patients and	1	6		Named Nurses are meeting with patients and their representatives to discuss actual or perceived	**21 April 2014**

No.	Recommendations	Number of times stated	Document Number	Reference	Details of action to be taken by ward/trust	Timescale
	their representatives and this is documented in the care documentation.				deprivation of liberty. Outcomes are recorded in the patients care plan.	
10	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.	1	17	5.3.3	Three staff, who took up post in December 2013, did not have MAPA at the time of the inspection, two of these staff completed their training in February, the other staff is scheduled to complete the training from 31st March – 4th April 2014	**21 February 2014**
	Information for patients and carers					
11	It is recommended the ward manager ensures any correspondence with advocacy services is clearly documented.	1	17	6.3.2	All correspondence with advocacy services is documented in the patients care plan	**Immediate and on-going**
	Additional Recommendations.					
12	It is recommended the ward manager ensures patients with additional needs are fully assessed particularly where there is evidence of comorbidity issues	1	17	5.3.1	Patients with additional needs are fully assessed by the MDT and appropriate referrals to other	**Immediate and on-going**

No.	Recommendations	Number of times stated	Document Number	Reference	Details of action to be taken by ward/trust	Timescale
	to ensure the needs of the patients are fully met.				services made.	
13	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.	1	17	5.3.3 (b)	The Belfast Trust has agreement in place with host Trust that a named Care Manager is in place for patients. The care manager is invited to regular meetings to update the MDT and the patient.	**Immediate and on-going**
14	It recommended the ward manager ensures a care plan in relation to discharge is completed for each patient.	1	17	5.3.3 (b)	All patients have an up to date discharge plan detailed in their care plan	**Immediate and on-going**
15	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.	1	17	5.3	A multidisciplinary assessment will be completed if a patient requires a specialist piece of equipment.	**Immediate and on-going**

NAME OF WARD MANAGER COMPLETING QIP	Assumpta Cullinan
NAME OF CHIEF EXECUTIVE / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Colm donaghy

Inspector assessment of returned QIP				**Inspector**	**Date**
		Yes	**No**		
A.	Quality Improvement Plan response assessed by inspector as acceptable	✓		Wendy McGregor	**12 March 2014**
B.	Further information requested from provider				

Appendix 1 – MHLD Reference Documents

MHLD Document Number	Legislation Title
1	AIMS -Older People(2009)
2	AIMS-Working Age Adults(2009)
3	AIMS-Learning Disabilities(2010)
4	Circular HSS(F)57/2009 – Residents' Monies
5	Complaints in HSC: Resolution & Learning (2009)
6	DHSSPS Interim Guidance - Deprivation of Liberty(2010)
7	DHSSPS Guidance - Restraint and Seclusion(2005)
8	Human Rights Act(1998)
9	Improving Dementia Services Reg Strategy(2011)
10	Learning Disability Service Framework(2012)
11	Mental Health(NI)Order(1986)
12	NICE Quality Standard 14-User experience(2011)
13	NICE Clinical Guideline 136 -User experience(2011)
14	OPCAT(2002)
15	Procedure for Reporting & Follow Up of SAIs(2010)
16	Promoting Quality Care(2009)
17	Quality Standards for HSC(2006)
18	Safeguarding VAs-Shared Responsibility(2010)

MHLD Document Number	Legislation Title
19	Safeguarding VAs-Protection Policy & Guidance(2006)
20	Service Framework for Mental Health & Well Being (2011)
21	UN Convention-Person with Disabilities(2006)
22	UN Convention-Rights of the Child(1989)
23	UTEC Guidance(2007)