The Regulation and Quality Improvement Authority

RQIA

Mental Health and Learning Disability

Unannounced Inspection

Moylena

Muckamore Abbey Hospital

Belfast Health and Social Care Trust

8 & 9 July 2014

npm national preventive mechanism

informing and improving health and social care

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Contents

1.0 General Information

Ward Name	Moylena
Trust	Belfast Health and Social Care Trust
Hospital Address	1 Abbey Road Antrim BT41 4SH
Ward Telephone number	(028) 9446 3333
Ward Manager	John Morgan (acting)
Email address	John.morgan@belfasttrust.hscni.net
Person in charge on days of inspection	John Morgan
Category of Care	Learning disability
Date of last inspection and inspection type	20 May 2014 Patient Experience Interview
Name of inspectors	Wendy McGregor Kieran McCormick

2.0 Ward profile

Moylena is a fourteen bedded ward on the Muckamore Abbey Hospital site. The purpose of the ward is to provide continuing care to male patients with a learning disability who present with behaviours that challenge. Moylena ward is a resettlement ward. All patients on Moylena had been assessed as fit for discharge. The discharge for all patients on the ward is delayed and all patients are awaiting discharge into community facilities as part of the on-going resettlement of patients in long stay wards on the hospital site.

There were ten patients on the ward on the first day of the inspection, this number increased to eleven on the second day of the inspection. None of the patients on the ward were detained in accordance with the Mental Health (Northern Ireland) Order 1986.

Patients on the ward have access to a multi-disciplinary team consisting of nursing and psychiatry. Access to speech and language therapy, occupational therapy, behaviour support, psychology is by referral. Independent advocacy services were available.

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.

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

4.0 Review of action plans/progress

An unannounced inspection of Moylena was undertaken on 8 & 9 July 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 18 & 19 June 2012 were evaluated. Inspectors were pleased to note that sixteen of twenty three recommendations had been fully met and compliance had been achieved in the following areas:

- Environmental changes to promote patients privacy had been made.
- Patients had access to advocacy services
- Information in relation to patients and relatives rights was available
- Information on how to make a complaint was available for patients and relatives
- Guidance on safeguarding vulnerable adults and child protection was included in the ward's induction procedures
- All staff had received up to date training in safeguarding vulnerable adults, infection control, handling patients' monies and child protection.
- Patients progress is evaluated on a daily basis
- The policy in relation to patient finances had been reviewed and updated.

However, despite assurances from the Trust, seven recommendations had not been fully implemented. Three recommendations had been partially met and four recommendations had not been met.

Six of these recommendations will require to be restated for a second time and one recommendation will require to be restated for a third 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 20 November 2013 were evaluated. The inspector was pleased to note that all of the recommendations had been fully met and compliance had been achieved in the following areas:

- Environmental areas had been improved.

- Patient advocates are invited to attend patient multi-disciplinary meetings.

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

The recommendations made following the finance inspection on 31December 2013 were evaluated. The inspector was pleased to note that three of four recommendations had been fully met and compliance had been achieved in the following areas:

- The trust have reviewed and updated their policy and procedures in relation to patient finances
- Staff were aware of the updated policy and were working to it
- Patients no longer purchase activity or occupational therapy materials as part of their therapeutic programme

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

Details of the above findings are included in Appendix 1.

5.0 Inspection Summary

Inspectors found that progress had been made in some aspects of care and treatment delivery on the ward since the last inspection. It was good to note that patients now have increased access to activities so that patients now have the opportunity to participate in ward based activities in addition to hospital based day care.

Environmental enhancements had been made to the ward to promote patient privacy and dignity.

Comprehensive individualised and person centred care plans had been developed for patients on the ward.

All the relatives who returned questionnaires stated they were happy with the care their relative received on the ward.

The number of patients had decreased as patients have been resettled into the community as part of the resettlement of patients from long stay wards.

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.

It was good to note that there were references to the Human Rights Act articles 3, 5, 8 and 14 throughout patients care documentation and staff demonstrated their knowledge in relation to Human Rights.

Inspectors reviewed care documentation specifically relating to capacity to consent for ten of the eleven patients on the ward on the days of the inspection and found that capacity to consent assessments had been undertaken for two patients out the ten reviewed.

There was no evidence in the care documentation reviewed by inspectors that capacity to consent to care and treatment assessments had been undertaken for eight patients out of the ten patients. Given that all of the patients on the ward will be transferring to the community as part of the on-going resettlement of long stay patients, inspectors were concerned to note that capacity to consent assessments had not been completed to assess patients' capacity to make such a major life changing decision. A recommendation has been made in relation to this.

Patient, relatives or advocate input in relation to capacity to consent assessments was not evidenced in the care documentation reviewed by inspectors on the days of the inspection. Four out of seven relative questionnaires returned stated that they had not been involved in any formal assessments in relation to capacity to consent to care and treatment. A recommendation has been made in relation to this

Inspectors noted reference to completing a Best interest and Decision Making checklist for specific interventions e.g. venepuncture. However there was no evidence in the care documentation reviewed that this checklist had been completed. A recommendation had been made in relation to this.

There was no evidence of multi-disciplinary discussion in relation to arrangements in place for decision making processes for the two patients that had been assessed as not having capacity to consent to care and treatment. A recommendation has been made in relation to this.

There was evidence in the care documentation reviewed of holistic assessment of needs. Care plans were person centred and individualised and had been developed to address each identified need.

There was no evidence in the care documentation reviewed that patients, relatives or advocates had been involved in the development of, or agreement to, the interventions detailed in care plans. Two of the seven relative questionnaires returned indicated that they had not been involved in the development of their relative's care plan. A recommendation has been made in relation to this.

A communication tool to support patients with communication in the form of a "communication passport" was available in two of the three sets of care documentation reviewed. One patient had a communication placemat to support them to communicate their needs in relation to eating and drinking.

A care plan in relation to communication was available in the three sets of care documentation reviewed by inspectors. There was no evidence of communication assessments in the three sets of care documentation reviewed, therefore inspectors could not establish whether or not care plans and communication passports specifically addressed individual patient's communication needs. Recommendations have been made in relation to this.

On the days of the inspection, the inspectors completed a direct observation of the ward environment. Inspectors noted that interaction between staff and patients was responsive, appropriate and respectful.

Inspectors observed staff engaging with patients and working towards meeting patients' individual needs. A 'communication dictionary' had been developed for one patient to aid staffs' interpretation of what the patient was communicating through their behaviours, words and gestures.
Inspectors noted that the risk screening tool had been completed for all patients in the three sets of care documentation reviewed. The dates of risk management plan reviews had been recorded however consideration of incidents or accidents since the previous review, and subsequent amendments to the risk management plans were not evidenced as part of this review. Inspectors noted that care documentation (body maps) to record any marks/bruising/ injury had been completed for one patient on ten occasions within a five week period. However, there was no evidence that the information contained within this documentation was being reviewed, monitored or used to inform care practices. Recommendations have been made in relation to this.

Unexplained injuries had been recorded on six out of the ten body maps, for this patient. However safeguarding vulnerable adult referrals had not been completed in respect of these unexplained injuries in line with the Trust policy. Inspectors met with the designated officer for the ward who confirmed that referrals for the injuries had not been received for this patient.

Each patient on the ward is scheduled to attend five sessions of day-care per week in Moyola which is a day-care facility on the hospital site. A ward based activity schedule was also available on the ward. Inspectors observed staff engaging with and supporting patients to participate in ward based activities on the days that they were not attending Moyola. Patients from Moylena also have access to a facility (Portview) to undertake daytime activities outside the ward environment.

Individualised assessments for therapeutic and recreational activities or individualised activity schedules for patients were not available on the days of the inspection. A recommendation has been made in relation to this.

There was evidence in the daily progress notes of ongoing monitoring of participation in, and outcomes of therapeutic activities.

Information in relation to advocacy services and how to access this service was available for patients and relatives.

The patient's charter of rights was on display on the ward. The ward information booklet also provided additional information and guidance in an easy read format. The three staff who met with inspectors were aware of the role and function of advocacy services and how to refer patients to this service.

The acting ward manager informed inspectors on the days of the inspections that there were currently no patients detained in accordance with the Mental Health (Northern Ireland) Order 1986. Inspectors noted individualised care plans were in place in relation to restrictive practices in the care documentation reviewed. Each care plan stated the nature of the restriction. Inspectors found that the rationale for each restrictive practice was unclear and did not support the level of restriction. A recommendation has been made in relation this.

Inspectors were concerned to note that one restrictive practice care plan stated a patient will always require a locked environment even when the patient moves into the community. There was no evidence in the care documentation reviewed to indicate the basis on which this decision had been taken. There was no evidence in the care documentation of the development or implementation of an intervention to consider ways of reducing this level of restriction and to help prepare patients for their transition into a community setting. A recommendation has been made in relation to this.

On the days of the inspection, inspectors observed a blanket restriction in the form of locked internal doors on the ward. The doors to one of the two day rooms were locked at all times while in use by patients, with entry and exit controlled by staff. There was no evidence in the care documentation reviewed to support the necessity of this practice or to give a clear rationale for this. Given that comprehensive risk assessments had not been completed for any of the patients as they were not considered necessary, it is unclear how the Trust could justify this level of restriction in terms of proportionality and necessity. A recommendation has been made in relation to this.

Whilst it was observed that internal doors were locked, inspectors noted that staff were prompt in responding to patients who wished to leave the room. Inspectors noted that restrictive practices pertaining to each patient were discussed at the monthly multidisciplinary meetings however the practices remained unchanged.

The acting ward manager informed inspectors that all patients in Moylena were medically fit for discharge therefore all of the patients on the ward were delayed in their discharge from hospital.

Inspectors reviewed care documentation in relation to three patients and noted each patient had a nursing discharge care plan completed. Two out of the three sets of care documentation reviewed contained minutes of discharge planning meetings. These meetings were attended by the patient's care manager.

Four of the seven relatives questionnaires returned to RQIA stated that they had not been involved in their relative's discharge planning and were unaware of a discharge plan for their relative. Inspectors discussed this with the Consultant Psychiatrist who informed inspectors all families were invited and encouraged to attend discharge planning meetings. There was no evidence in the care documentation reviewed of patients' relatives being invited or involved in discharge planning meetings, the reasons for relative/carer non-attendance or how information was being shared with patients' relatives/carers. A recommendation has been made in relation to this.

Inspectors were unable to find evidence of a discharge pathway for the discharge process for patients on Moylena. A recommendation has been made in relation to this.

The acting ward manager and senior trust representatives confirmed that the Health and Social Care Board are informed of delayed discharges.
Details of the above findings are included in Appendix 2.

On this occasion Moylena has achieved an overall compliance level of not compliant in relation to the Human Rights inspection theme of "Autonomy".

6.0 Consultation processes

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

Patients	**0 (direct observation undertaken)**
Ward Staff	**3**
Relatives	**0**
Other Ward Professionals	**2**
Advocates	**0**

Patients

Patients in Moylena had limited ability to verbally comment on their care and treatment on the ward. The inspectors undertook direct observations on the ward on the days of the inspection. Patients on the ward presented as relaxed in ward environment.

Relatives/Carers

The inspection was unannounced. There were no relatives available to speak with inspectors on the days of the inspection.

Ward Staff

Inspectors spoke with both registrant and non-registrant staff. All staff commented that they enjoy working on the ward and they feel well supported on the ward.

Other Ward Professionals

Inspectors spoke with two other ward professionals on the days of the inspection.

Advocates

The inspection was unannounced. There were no advocate's available to speak with inspectors on the days of the inspection.

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

Questionnaires issued to	Number issued	Number returned
Ward Staff	**20**	**8**
Other Ward Professionals	**5**	**2**
Relatives/carers	**11**	**7**

Ward Staff

Eight questionnaires were returned by ward staff in advance of the inspection. Information contained within the staff questionnaires demonstrated that staff were aware of Deprivation of Liberty Safeguards (DOLS) – interim guidance however staff had not received training in the areas of Human Rights and capacity to consent. All staff stated they were aware of restrictive practices on the ward. Examples of restrictive practices as reported by staff included "secure environment, enhanced observations, patients monies are secured in a locked drawer." Not all staff had received training in restrictive practices.

All of the staff who returned a questionnaire stated they had received training on meeting the needs of patients who need support with communication and were aware of alternative methods of communication. Staff indicated that processes were in place to meet patients' individual communication needs. Staff reported that all patients had access to therapeutic and recreational activities.

Other Ward Professionals

Two questionnaires were received from a social worker and member of the medical team in advance of the inspection. Both staff reported that they had received training in capacity to consent and Human Rights and were aware of Deprivation of Liberty Safeguards (DOLS) interim guidance.

Staff indicated that they were aware of restrictive practices used on the ward. Both staff stated patients' communication needs were assessed and that the ward had processes in place to meet each individual patient's communication needs. One staff indicated that the ward did not have information on the Mental Health (Northern Ireland) Order 1986, detention processes, making a complaint and advocacy services in easy read format suggesting it was "not possible to do this as patients not able to understand written material or modified material. Where appropriate information is explained verbally."

Staff highlighted the complex and challenging needs presented by the patient population on the ward. Staff stated "the staff team are experienced and work sensitively with the patients. Each patient is supported as an individual with specific needs."

Relatives/carers

Seven relative/carer questionnaires were returned in advance of the inspection. Six out of the seven relative/carers stated their relative had received good to excellent care on Moylena. One relative/carer did not

answer the question. Five relatives/carers were concerned about their relatives ability to consent and four stated a formal capacity to consent assessment had been completed, although they had not been involved in the assessment. Two relatives had not been involved in any assessments in relation to therapeutic assessment. One relative was not sure if their family member attends day care and one relative indicated that they would like more information in relation to day time activities. Six relatives indicated that their family member required a communication assessment. Relatives commented that information was available on patients' rights, although their family member would "not understand" the information. All relatives were aware of restrictive practices on the ward.

One relative stated "my relative receives excellent care in Moylena ward."

Specific issues raised by relatives are included in the inspection findings.

7.0 Additional matters examined/additional concerns noted

Complaints

Inspectors reviewed complaints received by the ward between the 1 April 2013 and the 31 March 2014. Three complaints had been received. One complaint related to food and nutrition and two to environmental issues. All of the complaints were recorded as having been resolved to the satisfaction of the complainant. Inspectors found the ward's complaint procedure to be in accordance with the Trust's policy and procedure. Inspectors noted that information relating to the complaints procedure was available to patients and their carer/relatives. Inspectors noted that there was no method of recording local resolved complaints. A recommendation has been made in relation to this.

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 18 & 19 June 2012

No.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	It is recommended that the arrangements for promoting patients' privacy are reviewed and that all patients are provided with curtains / screens, as appropriate, in their bed space areas. It is recommended that patients' privacy in the dormitory area is maximised and that dormitory windows are adequately covered. It is recommended that all damaged furniture is repaired or replaced as appropriate. It is recommended that patients' have access to personal items and objects on the ward, as appropriate to their individual preferences and needs.	Inspectors completed an observation of the ward environment. Screens had been provided to promote patients privacy. Patients privacy in the dormitory area had been maximised and windows were adequately covered to promote patient dignity. Furniture was noted to be well maintained. Arrangements were in place to replace two sofas in the day room. Patients had access to their personal property as appropriate to their individual needs.	**Fully met**
2	It is recommended that activity assessments are undertaken with all patients and that patients are provided with a range of individual and group activities on the ward in accordance with their needs and preferences.	Individual activity assessments were not available on the day of the inspection. Patients did not have individual activity schedules. A ward based group activity schedule	**Partially met**

		was available and patients were noted to be participating in ward based activities on the days of the inspection. This recommendation will restated for a third time	
3	It is recommended that the arrangements for patients to have access to independent advocacy services are reviewed and that advocacy services are developed within the ward.	Independent advocacy services are available for all patients. Information on how to access the service was clearly displayed on entry to the ward and in the ward information booklet.	**Fully met**
4	It is recommended that all patients and their relatives / representatives are informed of their rights on the ward and that these rights are promoted.	Information in relation to patients and their relatives rights on the ward is displayed in the communal area and in the ward information booklet	**Fully met**
5	It is recommended that patients and their relatives are provided with opportunities to raise any concerns or to complain about services provided.	Information on how to make a complaint is displayed in the ward communal area and in the ward information booklet. The acting ward manager stated any concerns / complaints raised by patients and their relatives are recorded in the patients care documentation. There was no method of recording local	**Fully met**

		resolved complaints for the purposes of audit. A new recommendation has been made in relation to this.	
6	It is recommended that all policies and procedures pertaining to safeguarding vulnerable adults are reviewed in accordance with Trust timescales.	Policies and procedures pertaining to safeguarding vulnerable adults had been reviewed and updated. Up to date 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.	**Fully met**
7	It is recommended that the ward's induction procedures are reviewed and that guidance on the safeguarding of vulnerable adults and child protection is included.	Inspectors reviewed the wards induction procedures and noted that guidance on safeguarding vulnerable adults and child protection was included.	**Fully met**
8	It is recommended that all staff undertake mandatory training in the areas of safeguarding vulnerable adults, infection control, handling patient's property and finances and child protection.	Training records showed that all staff had received up to date training in Vulnerable Adults, infection control, handling patients property and child protection.	**Fully met**
9	It is recommended that existing ward protocols are developed to ensure that staff consider implementation of the safeguarding vulnerable adults procedures in the	Up to date information in relating to adult safeguarding including protocols was available to guide staff on the procedure	**Not met**

	event of a patient sustaining or presenting with unexplained marks, bruises etc.	to follow in the event of a patient sustaining or presenting with unexplained marks, bruises etc. However inspectors found that this protocol had not been followed on the days of the inspection. One patient had six body charts completed for unexplained marks and bruising however a safeguarding vulnerable adult referral had not been completed in line with trust policy and procedure. This recommendation will be restated for a second time.	
10	It is recommended that risk screening tools are signed on completion.	Risk screening tools had been signed by the patients named nurse, however there was no evidence that the line manager had reviewed the risk screening tool and signed same as per (regional) policy and procedure. This recommendation will be restated for a second time.	**Partially met**
11	It is recommended that comprehensive risk assessments are completed for patients where significant risks have been identified.	On the days of the inspection, all patients had a risk screening tool completed. Comprehensive risk assessments had not been completed for any of the patients in Moylena. There was no rationale recorded for this decision.	**Fully met**

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		A new recommendation has been made in relation to this.	
12	It is recommended that patients' progress is evaluated and recorded on a daily basis.	Inspectors noted in the three sets of care documentation reviewed that patients progress was evaluated and recorded on a daily basis	**Fully met**
13	It was recommended that representatives of patients are provided with regular opportunities to comment on the care and treatment available to patients in the ward and that the ward is more accessible to patients' visitors.	Two out of the seven relative / carers questionnaires returned stated they had not had the opportunity to be involved in decisions related to their relatives care and treatment. There was no evidence of relative / carer involvement in the three sets of care documentation reviewed by inspectors on the days of the inspection. This recommendation will be restated for a second time. Relatives commented that they could visit at any time they wished. One relative indicated that due to ill health visiting the ward is difficult however staff had facilitated the patient visiting their relative in the relatives own home.	**Partially met**
14	It is recommended that referrals to the hospital advocacy service should be considered for those patients who are involved in incidents on the ward.	Eight patients had been referred to advocacy services. Families were involved for other patients on the ward and did not wish for advocacy services to	**Fully met**

		become involved in their relatives care.	
15	It is recommended that patients and or their carers are advised of their rights in relation to accessing information held by the ward about them.	Information advising patients and or their carers in relation to accessing information held about them was available in the ward information booklet. The information was also available in easy read format.	**Fully met**
16	It is recommended that the Code of Behaviour is developed and reflects the specific arrangements for Moylena staff, patients and visitors.	All staff working on the ward were aware of their own professional codes of conduct .	**Fully met**
17	It is recommended that all restrictive practices in use on the ward are evaluated in relation to their impact on all patients and that individual patients' rights are not compromised by the needs of other patients.	Restrictive practice documentation was available in the three sets of care documentation reviewed. However inspectors completed ward observations during the days of the inspection and noted a "blanket restriction" where seven patients where in a day room with staff, and the all exit doors were locked. The necessity for this practice was not reflected in the care documentation reviewed and a rationale for this level of restriction was not contained within the patients care documentation. This recommendation will be restated for a second time	**Not met**
18	It is recommended that patients' capacity to consent to specific interventions is assessed regularly and documented.	Ten sets of care documentation were reviewed in relation to capacity to consent assessments. Inspectors found that a	**Not met**

		capacity to consent assessment had been undertaken for two out of ten patients. Care plans had been completed in relation to capacity to consent in the three sets of care documentation reviewed. This detailed indicators of when the patient was consenting or otherwise to interventions for example venepuncture. The care plan referenced how the patient indicates that they are not consenting, in this instance the documentation states staff should assess the patient using the "best interest pathway". However there was no evidence that this had been used. This recommendation will be restated for a second time.	
19	It is recommended that patients who cannot consent to interventions are provided with independent advocacy services and that best interests decisions are multi-disciplinary and in accordance with the principles of necessity and proportionality.	In the three sets of care documentation reviewed there was no evidence that patients who cannot consent were provided with an advocate. There was evidence that best interest decisions were discussed at the patients' multi-disciplinary meetings but no formal documentation to support this, evidencing decisions were in accordance with the principles of necessity and proportionality. This recommendation will restated for a	**Not met**

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		second time	
20	It is recommended that all interventions are included in the patients' care plan and that this is evaluated on a regular basis.	All interventions included in patients care plans were evaluated on a regular basis. Care plans were reviewed within the agreed time scale.	**Fully met**
21	It is recommended that patients' representatives are involved in decisions pertaining to patients' expenditure – particularly when choosing retailers and price ranges.	The policy and procedure in relation to the management of patients monies has been developed following The Regulation Quality Improvement Authority review and recommendations.	**Fully met**
22	It is recommended that all withdrawals from the Patient's Property Account are entered on the patients' ledger and administered by ward staff in accordance with the Trust's procedures.	Inspectors reviewed patients ledgers and noted withdrawals had been recorded and administered by staff in accordance with Trust procedures.	**Fully met**
23	It is recommended that all staff undertake training in child protection as appropriate to their role and responsibility.	Training records showed all staff had received training in Child protection.	**Fully met**

Appendix 1

Follow-up on recommendations made following the patient experience interviews inspection on 20 November 2013

No.	Reference	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	5.3.1 (f)	It is recommended the ward manager ensures the glass on two of the upstairs sleeping areas windows is replaced	Glass on two of the windows had been replaced.	**Fully met**
2	5.3.1(a)	It is recommended the ward manager ensures that all patients have an individual risk assessment completed in relation to the opaque covering on the glass on all of the windows in the sleeping area.	Risk assessments have been completed in relation to the opaque covering on the glass on all of the windows in the sleeping area.	**Fully met**
3	6.3.2	It is recommended the ward manager ensures the patient advocate is invited to multidisciplinary meetings.	Inspectors noted evidence of invitation to the patient advocates to attend patient multi-disciplinary meetings	**Fully met**

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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.	There was no record of staff who can access the Bisley drawer on the ward. This recommendation will be restated for a second time	**Not 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 Trust has reviewed and updated their policy on "Patients Finances and Patient Property – Policy for inpatients within Mental Health and Learning Disability Hospitals" March 2014. Inspectors noted that only patients who use the leased bus are charged equitably for it use as per the policy. Senior management informed inspectors that patients are not charged for the use of transport for the purposes of resettlement or medical appointments.	**Fully met**
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.	Staff interviewed where aware of the procedure to follow in relation to charging for transport. The policy was available and staff were working to it.	**Fully met**
4	It is recommended that the Trust review the requirement for patients to buy their activity or occupational therapy materials as part of a therapeutic programme.	The Trust have reviewed the requirement for patients to purchase their activity or occupational therapy materials as part of a therapeutic programme. This practice has now ceased.	**Fully met**

Ward Self-Assessment	
Statement 1: Capacity & Consent • **Patients' capacity to consent to care and treatment is monitored and re-evaluated regularly throughout admission to hospital.** • **Patients are allowed adequate time and resources to optimise their understanding of the implications of their care and treatment.** • **Where a patient has been assessed as not having the capacity to make a decision there are robust arrangements in place in relation to decision making processes that are managed in accordance with DHSSPS guidance.** • **Patients' Article 8 rights to respect for private and family life & Article 14 right to be free from discrimination have been considered**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
When a patient has been assessed as not having the capacity to make a decision, the MDT make decisions for the patients, (using the best interest check list and decision record) with consultation with the patient and with relatives/carers and advocates, considering the persons best interest. Patients/carers and relatives are involved in the completion and review (when there is a change in the risk and at a minimum of 6 monthly) of 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 highlighted 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. Easy read documentation available for patients and families. – consent, human rights, MHO Relatives are encouraged to be actively involved through open visiting, regular phone calls and invites to MDT meetings Visits by patients to the family homes are encouraged and facilitated	Moving towards compliance

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	
Easy read information on consent, The Human Rights Act (1998) and The Mental Health (Northern Ireland) Order 1986 was available for patients and families. There was evidence in the three sets of care documentation reviewed by inspectors that patients' human rights had been considered with reference to the Human Rights Articles 3, 5, 8 and 14. Inspectors spoke with three staff who demonstrated their knowledge in relation to capacity to consent and Human Rights. Inspectors reviewed care documentation specifically relating to capacity to consent for ten of the eleven patients on the ward on the days of the inspection and found that capacity to consent assessments had been undertaken for two patients out the ten reviewed. There was no evidence in the care documentation reviewed by inspectors that capacity to consent to care and treatment assessments had been undertaken for eight patients out of the ten patients. Given that all of the patients on the ward will be transferring to the community as part of the on-going resettlement of long stay patients, inspectors were concerned to note that capacity to consent assessments had not been completed to assess patients' capacity to make such a major life changing decision. A recommendation has been made in relation to this.	Not compliant

Patient, relatives or advocate input in relation to capacity to consent assessments was not evidenced in the care documentation reviewed by inspectors on the days of the inspection. Four out of seven relative questionnaires returned stated that they had not been involved in any formal assessments in relation to capacity to consent to care and treatment. A recommendation has been made in relation to this Inspectors noted reference to completing a Best interest and Decision Making checklist for specific interventions e.g. venepuncture. However there was no evidence in the care documentation reviewed that this checklist had been completed. A recommendation had been made in relation to this. There was no evidence of multi-disciplinary discussion in relation to arrangements in place for decision making processes for the two patients that had been assessed as not having capacity to consent to care and treatment. A recommendation has been made in relation to this. There was evidence in the care documentation reviewed to guide staff when a patient is indicating that they are consenting to care and treatment and when a patient is indicating they are not. However, there was no evidence within the daily progress notes relating to three patients to indicate patient consent to daily care activities. A recommendation has been made in relation to this. Four of ten staff who completed and returned questionnaires indicated that they had not received training related to Human Rights. A recommendation has been made in relation to this. Six of ten staff who completed and returned questionnaires indicated that they had not received training relating to capacity to consent to care and treatment. A recommendation had been made in relation to this.	

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 assessment and plans of care to manage identified risk. Care plans are reviewed when there is a change in risk and at a minimum of 6 monthly Risk screening tool are completed and if deemed necessary by the MDT, patients will also have a comprehensive risk assessment. CRA is reviewed when there is a change in risk and at a minimum of 6 monthly – there are no CRAs required in the ward at present Patients/carers and relatives are involved in the completion and review of their 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 highlighted Patients have communication passports and communication place mats Patients can be referred to Speech & Language therapy when required	Substantially compliant

Staff training is up to date. 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	
Inspectors reviewed care documentation relating to three patients. There was evidence in the care documentation reviewed of holistic assessment of needs. Care plans were person centred and individualised. References to the Human Rights Articles 3, 5, 8 and 14 were evident in the care documentation. Care plans had been developed to address each identified need. There was no evidence that patients, relatives or advocates had been involved in the development of or agreement to the interventions detailed in care plans. Two of the seven relative questionnaires returned indicated that they had not been involved in the development of their relative's care plan. A recommendation has been made in relation to this. A communication tool to support patients with communication in the form of a "communication passport" was available in two of the three sets of care documentation reviewed. One patient had a communication placemat to support them to communicate their needs in relation to eating and drinking. A care plan in relation to communication was available in the three sets of care documentation reviewed by inspectors. There was no evidence of communication assessments in the three sets of care documentation reviewed, therefore inspectors could not establish whether or not care plans and communication passports specifically addressed individual patient's communication needs. Recommendations have been made in relation to this. On the days of the inspection, the inspectors completed a direct observation of the ward environment. Inspectors noted that interaction between staff and patients was responsive, appropriate and respectful. Inspectors observed staff engaging with patients and working towards meeting patients' individual needs. A 'communication dictionary' had been developed for one patient to aid staffs' interpretation of what the patient was communicating through their behaviours, words and gestures. This tool had not been developed or	Not compliant

implemented for the other patients on the ward. Inspectors discussed this with the acting ward manager and recommended that it would be beneficial for all patients to have a "communication dictionary" completed. This would support the patients with their transition into community. A recommendation has been made in relation to this. Inspectors noted that the risk screening tool had been completed for all patients in the three sets of care documentation reviewed. This documentation was not consistently signed by the line manager. A recommendation has been made in relation to this. The rationale for not proceeding to a comprehensive risk assessment was not recorded in the risk screening documentation. A recommendation has been made in relation to this. The dates of risk management plan reviews had been recorded however consideration of incidents or accidents since the previous review, and subsequent amendments to the risk management plans were not evidenced as part of this review. Inspectors noted that care documentation (body maps) to record any marks/bruising/injury had been completed for one patient on ten occasions within a five week period. However, there was no evidence that the information contained within this documentation was being reviewed, monitored or used to inform care practices. Two of the completed body maps related to falls however this information was not reflected in the review of the patient's care plans, moving and handling or falls risk assessments. Recommendations have been made in relation to this. Unexplained injuries had been recorded on six out of the ten body maps, for this patient. However safeguarding vulnerable adult referrals had not been completed in respect of these unexplained injuries in line with the Trust policy. Inspectors met with the designated officer for the ward who confirmed that referrals for the injuries had not been received for this patient. One patient's family had raised concerns in the relative/carer returned questionnaire distributed in advance of this inspection about not always being informed of injuries. The family also reported that they had observed an injury on their relative and had asked the staff about it, but they were not provided with an explanation. Inspectors reviewed the care documentation in relation to the concerns reported by the patient's relative via returned questionnaire. Inspectors noted the relatives concerns had not been recorded and there was no evidence that staff had discussed this or provided an explanation to the patient's relative. Inspectors raised this with the acting ward manager during the inspection. The acting ward manager was not aware of this. Recommendations have been made in relation to this.	

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 Patients attend day-care on a sessional basis – off the ward Patients participate in therapeutic activities on the ward, these include foot spas, jigsaw and art work A programme of available activities is on display The Human Rights Act is available in the ward, all staff are aware of and consider Article 8 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	Moving towards compliance
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	

Inspectors noted that each patient on the ward is scheduled to attend five sessions of day-care per week in Moyola which is a day-care facility on the hospital site. A ward based activity schedule was also available on the ward. Inspectors observed staff engaging with and supporting patients to participate in ward based activities on the days that they were not attending Moyola. Patients from Moylena also have access to a facility (Portview) to undertake daytime activities outside the ward environment. Individualised assessments for therapeutic and recreational activities or individualised activity schedules for patients were not available on the days of the inspection. A recommendation has been made in relation to this. One relative/carer indicated via returned questionnaire that they would like more information on what activities their relative undertakes. Another relative indicated that they were unsure if their relative attends day-care. A recommendation has been made in relation to this. There was evidence in the daily progress notes of ongoing monitoring of participation in, and outcomes of therapeutic activities. The acting ward manager informed inspectors on the first day of inspection that one patient who was due to attend day-care was unable to avail of this due to a shortage of staff at the hospital day care facility. A recommendation has been made in relation to this. There was no evidence of any occupational therapy input on the ward for purposes other than assessment of acute or chronic physical conditions. A recommendation has been made in relation to this.	Moving towards compliance

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:	
There are no patients detained in Moylena 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 easy read A guide to The Human Rights Act is available in easy read Easy read leaflets available re levels of observation 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	

There was evidence in the care documentation reviewed by inspectors that consideration had been given to the impact of restrictive practices on the patients Human Rights articles 3, 5, 8 and 14. Easy read versions of The Mental Health (Northern Ireland) Order 1986, The Human Rights Act 1998 and the complaints procedure were available on the ward. However, communication assessments were not completed for patients therefore it is unclear if the easy read format meets the communication needs of these patients. A recommendation has been made in relation to this. Information in relation to advocacy services and how to access this service was available for patients and relatives. The patient's charter of rights was on display on the ward. The ward information booklet also provided additional information and guidance in an easy read format. The three staff who met with inspectors were aware of the role and function of advocacy services and how to refer patients to this service. The nurse in charge informed inspectors that eight of the ten patients on the ward had been referred to advocacy services. Two patients' families did not want advocacy involved as they had agreed to act as an advocate on behalf of their relative. Two of seven relatives who returned their questionnaires stated that they did not know how to access advocacy services. A recommendation has been made in relation to this.	Substantially 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 restrictive practice is required, 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	Substantially compliant
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	

The acting ward manager informed inspectors on the days of the inspections that there were currently no patients detained in accordance with the Mental Health (Northern Ireland) Order 1986. Inspectors noted individualised care plans were in place in relation to restrictive practices in the care documentation reviewed. Each care plan stated the nature of the restriction. Inspectors found that the rationale for each restrictive practice was unclear and did not support the level of restriction. For example, one restrictive practice care plan simply stated the patient required a locked environment because they had a severe learning disability – the risks associated with this patient being supported in an open ward were not documented. Another plan stated the patient required a locked environment as they were unaware of complex dangers, however there was no assessment to establish what these complex dangers were. A recommendation has been made in relation this. There was reference throughout the care documentation reviewed on the potential impact of restrictive practices on the patients Articles 3, 5 and 8 Human Rights. Inspectors were concerned to note that one restrictive practice care plan stated a patient will always require a locked environment even when the patient moves into the community. There was no evidence in the care documentation reviewed to indicate the basis on which this decision had been taken. There was no evidence in the care documentation of the development or implementation of an intervention to consider ways of reducing this level of restriction and to help prepare patients for their transition into a community setting. A recommendation has been made in relation to this. On the days of the inspection, inspectors observed a blanket restriction in the form of locked internal doors on the ward. The doors to one of the two day rooms were locked at all times while in use by patients, with entry and exit controlled by staff. There was no evidence in the care documentation reviewed to support the necessity of this practice or to give a clear rationale for this. Given that comprehensive risk assessments had not been completed for any of the patients as they were not considered necessary, it is unclear how the Trust could justify this level of restriction in terms of proportionality and necessity. A recommendation has been made in relation to this. Relative feedback obtained though questionnaires indicated that relatives were aware of restrictions in place. However there was no evidence of patient, relative or advocate involvement in assessment and decisions for the use of restrictive practices. Whilst it was observed that internal doors were locked, inspectors noted that staff were prompt in responding to patients who wished to leave the room. Inspectors noted that restrictive practices pertaining to each patient were discussed at the monthly multidisciplinary meetings however the practices remained unchanged.	Not compliant

Ward Self-Assessment

Statement 6: Discharge planning • **Patients and/or their representatives are involved in discharge planning at the earliest opportunity.** • **Patients are discharged home with appropriate support or to an appropriate community setting within seven days of the patient being assessed as medically fit for discharge.** • **Delayed discharges are reported to the Health and Social Care Board.** • **Patients' Article 8 rights to respect for private and family life have been considered.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
Weekly MDT discharge meetings take place in the ward - discharge planning considers the individually assessed needs of the patient - care managers attend these meetings. The care manager communicates the discharge plan to the relatives following the meeting. Relatives and advocates have been invited to these meetings. 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	Moving towards compliance
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
The acting ward manager informed inspectors that all patients in Moylena were medically fit for discharge therefore all of the patients on the ward were delayed in their discharge from hospital. Inspectors reviewed care documentation in relation to three patients and noted each patient had a nursing discharge care plan completed. Two out of the three sets of care documentation reviewed contained minutes of discharge planning meetings. These meetings were attended by the patient's care manager. Four of the seven relatives questionnaires returned to RQIA stated that they had not been involved in their relative's discharge planning and were unaware of a discharge plan for their relative. Inspectors discussed this	Not compliant

with the Consultant Psychiatrist who informed inspectors all families were invited and encouraged to attend discharge planning meetings. There was no evidence in the care documentation reviewed of patients' relatives being invited or involved in discharge planning meetings, the reasons for relative/carer non-attendance or how information was being shared with patients' relatives/carers. A recommendation has been made in relation to this. The Consultant Psychiatrist informed inspectors that each patient's responsible Trust provided an occupational therapy service for the purpose of resettlement. There was no evidence of input from occupational therapy, speech and language therapy or behavioural support in relation to discharge and resettlement. A recommendation has been made in relation to this. Inspectors were unable to find evidence of a discharge pathway for the discharge process for patients on Moylena. A recommendation has been made in relation to this. The acting ward manager and senior trust representatives confirmed that the Health and Social Care Board are informed of delayed discharges.	

Ward Manager's overall assessment of the ward's compliance level against the statements assessed	COMPLIANCE LEVEL
	MOVING TOWARDS COMPLIANCE

Inspector's overall assessment of the ward's compliance level against the statements assessed	COMPLIANCE LEVEL
	Not compliant

Quality Improvement Plan

Unannounced Inspection

Moylena, Muckamore Abbey Hospital

8 & 9 July 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 ward manager, operations manager hospital manager, consultant psychiatrist and other Trust representatives on the day of the inspection visit.

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

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
1	5.3.1 (a)	It is recommended that the ward manager ensures that activity assessments are undertaken with all patients and that patients are provided with a range of individual and group activities on the ward in accordance with their needs and preferences	3	30 August 2014	Every patient has an activity assessment as part of their assessment of needs. This assessment details patients' needs and preferences. Individual activity schedules are available for all patients. All patients have the opportunity to select from the ward activity schedule
2	5.3.1 (c)	It is recommended that existing ward protocols are developed to ensure that staff consider implementation of the safeguarding vulnerable adults procedures in the event of a patient sustaining or presenting with unexplained marks, bruises etc.	2	Immediate and ongoing	A flowchart has been developed to ensure that if marks are observed on a patient, a body chart is completed and the patient is referred to the MO if required. A review of the notes takes place at this stage to ascertain a possible cause or previous incident. When a cause cannot be established and the marks are unexplained, this will be discussed within the MDT to consider a referral to the adult safeguarding team where appropriate.
3	5.3.1 (a)	It is recommended that the ward manager ensures that risk screening tools are signed on completion.	2	Immediate and ongoing	All current risk screening tools are signed.
4	5.3.3 (b)	It was recommended that representatives of patients are	2	Immediate	The assessment details to what level the patients

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
		provided with regular opportunities to comment on the care and treatment available to patients on the ward and that the ward is more accessible to patients' visitors.		and ongoing	representative wish to be involved in their relatives care and treatment. The assessment also indicates how and when the representative wishes to be contacted. A record of this contact is recorded in the progress evaluation and signed by the patients representative if applicable. There is a visiting room available in the ward.
5	5.3.1.(a)	It is recommended that the ward manager ensures that all restrictive practices in use on the ward are evaluated in relation to their impact on all patients and that individual patients' rights are not compromised by the needs of other patients	2	2 October 2014	The use of restrictive practice in the ward has been reviewed individually for each patient. All restrictive practices in use are evaluated in relation to their impact on patients and individual patients' rights and ensure the needs of other patients are not compromised. This is documented in the patients care plan.
6	5.3.1 (f)	It is recommended that the ward manager ensures that patients' capacity to consent to specific interventions is assessed regularly and documented.	2	Immediate and ongoing	Patient consent to care and treatment is assessed and recorded in their assessment of needs. This includes how the treatment or care is and will be delivered and how the patient demonstrates consent. If a patient does not consent to a particular activity this is also recorded in the assessment. Consent to care and treatment is

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
					reassessed and reviewed as part of the on-going care plan review
7	5.3.1 (f)	It is recommended that the ward manager ensures that patients who cannot consent to interventions are provided with independent advocacy services and that best interests decisions are multi-disciplinary and in accordance with the principles of necessity and proportionality.	2	Immediate and ongoing	The assessment of capacity to make non-routine or more serious decisions are discussed with the MDT and if required/necessary are recorded using the best interest check list and decision record, in consultation with relevant others i.e. the patient and relatives/carers and advocates, and considering the persons best interest.
8	5.3.1 (f)	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.	2	2 October 2014	Patients' Finances and Private Property – Policy for Inpatients within Mental Health and Learning Disability Hospitals has been reviewed to include a proforma for completion and associated guidance for staff, in relation to accessing the key to the Bisley drawer, and the reason for access.
9	5.3.1 (a)	It is recommended that the ward manager ensures that following completion of the risk screening tool, the rationale for not proceeding to a	1	2 October 2014	As per promoting quality care addendum for adult learning disability services, following completion of the Risk Screening Tool, a decision is made at the

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
		comprehensive risk assessment is agreed by the multi-disciplinary team and this is recorded on the documentation as per Promoting Quality Care Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services 2010			MDT meeting as to whether a Comprehensive Risk Assessment is required, the rationale for not proceeding to a comprehensive risk assessment is recorded on the Risk Screening Tool documentation
10	5.3.1 (f)	It is recommended that the multi-disciplinary team ensure that all patients have their capacity to consent assessed and ensure that all reasonable adjustments are taken in order to obtain consent.	1	Immediate and ongoing	When a patient does not have 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. All reasonable adjustments are taken in order to obtain consent and when required recorded in the progress evaluation
11	5.3.1 (f)	It is recommended that the ward manager ensures that patients and or/ their representatives are involved in any formal assessments in relation to capacity to consent, and that this involvement or otherwise is recorded in the patients care documentation.	1	Immediate and ongoing	When a formal assessment in relation to capacity to consent is required to make non-routine or more serious decisions, these are discussed with the MDT and when required the best interest check list and decision record is completed, in consultation with relevant others i.e. the patient

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
					and relatives/carers and advocates. The assessment of needs details to what level the patients representative wish to be involved in their relatives care and treatment
12	5.3.1 (f)	It is recommended that the ward manager ensures that patients who have been assessed as not having capacity to consent to specific interventions / decisions, have a Best Interest and decisions making checklist completed by the multi-disciplinary team	1	Immediate and ongoing	The assessment of capacity to make non-routine or more serious decisions (i.e. other than to preserve the life, health or well-being of an individual) are discussed with the MDT and recorded using the best interest check list and decision record, in consultation with relevant others i.e. the patient and relatives/carers and advocates, and consider the persons best interest.
13	5.3.1 (f)	It is recommended that the ward manger ensure that staff assess patients consent to daily care activities and that this is recorded in the patients daily progress notes.	1	Immediate and ongoing	Patient consent to daily care activities is recorded in their assessment of needs. This includes how the treatment or care is and will be delivered and how the patient demonstrates consent. If a patient, who has previously demonstrated that they are consenting to an activity, does not consent and when all reasonable adjustments are taken in order to obtain consent, this is recorded in the patients

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
					daily progress notes and evaluated/reviewed .
14	7.3 (c)	It is recommended that the ward manager ensures that all staff on the ward receive training in relation to the potential impact of care and treatment on the Human Rights of patients .	1	31 December 2014	All staff on the ward will have received human rights training by 31st December
15	5.3.1 (f)	It is recommended that the ward manager ensures that all staff attend training on capacity to consent.	1	31 December 2014	All staff in the ward will have received Human Rights training by 31st December, which includes training in relation to capacity to consent
16	5.3.3 (b)	It is recommended that the ward manager ensures that patients and / their representatives have the opportunity to contribute to the development of patient care plans.	1	Immediate and ongoing	Patients are involved in the development of their care plans at a level appropriate to them, patients will sign to indicate their involvement or if the patient is unable or declines to sign, the named nurse will indicate this. The assessment details to what level the patients representative wish to be involved in their relatives care and treatment. The assessment also indicates how and when the representative is contacted. A record of this contact is recorded in the progress evaluation and signed by the patients

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
					representative if they wish.
17	5.3.1 (a)	It is recommended that the ward manager ensures that all patients who require support with communication have a communication assessment completed.	1	31 December 2014	All patients who require support with communication are referred to Speech & Language for a communication assessment
18	5.3.3 (a)	It is recommended that the ward manager ensures that following a communication assessment, a communication tool is developed and implemented to support patients with their communication.	1	2 October 2014	If following a Speech and Language assessment, the assessment indicates a communication tool is appropriate, an individual communication tool is developed to support patients communication needs
19	5.3.3 (a)	It is recommended that the ward manager ensures that consideration is given to developing a tool for all patients similar to the "communication dictionary" developed by staff for one patient in Moylena to ensure that the knowledge that staff working on the ward have is shared with staff who will be supporting these patients in the future.	1	2 January 2015	If deemed appropriate, following a Speech and Language assessment, patients have communication aids developed appropriate to their individual needs.
20	5.3.1 (a)	It is recommended that the ward manager reviews and signs the risk screening tool on completion as per	1	Immediate and ongoing	All current risk screening tools are reviewed and signed by the Ward Manager on completion.

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
		Promoting Quality Care Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services 2010.			
21	5.3.1 (b)	It is recommended that the ward manager ensures that patients and or their representatives are involved in the risk screening tool, and a clear rationale is recorded when this is not possible.	1	2 October 2014	Patients and or their representatives will be involved in the completion of risk screening tools required in Moylena. If they are not involved a clear rationale is recorded.
22	5.3.1 (c)	It is recommended that the ward manager ensures that a vulnerable adults referral is completed for patients who sustain explained and/or unexplained injuries as per hospital policy.	1	Immediate and ongoing	A flowchart has been developed to ensure that if marks are observed on a patient, a body chart is completed and the patient is referred to the MO if required. A review of the notes takes place at this stage to ascertain a possible cause or previous incident. When a cause cannot be established and the marks are unexplained, this will discussed within the MDT to consider a referral to the adult safeguarding team where appropriate.
23	5.3.1 (a)	It is recommended that the ward manager ensures that patients care plans and risk assessments are reviewed and updated following incidents or accidents.	1	Immediate and ongoing	The patients care plan and relevant risk assessment is reviewed and updated following an incident or accident.

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
24	5.3.2 (d)	It is recommended that the ward manager ensures that patient representative's families are informed of any incidents / accidents and that this is recorded in the patients care documentation.	1	Immediate and ongoing	Patient representatives or families are informed of any incidents / accidents. This information is recorded in the patients care documentation.
25	5.3.3 (b)	It is recommended that the ward manager ensures that patient's representatives are involved in and aware patients' recreational and therapeutic assessment and activity plan.	1	2 October 2014	The assessment details to what level the patients representative wish to be involved in their relatives care and treatment. The assessment also indicates how and when the representative wishes to be contacted. Recreational and therapeutic assessments and activities are discussed during this contact.
26	6.3.1	It is recommended that the Trust ensures that patients scheduled daycare is not cancelled due to staff shortages.	1	Immediate and ongoing	Scheduled daycare is only cancelled in exceptional circumstances to ensure safe and effective care i.e. unplanned staff absences or increased levels of observations in the wards. In these circumstances health care support workers (band 3) from daycare may need to temporarily transfer to the wards. All cancellations are discussed with the Operations Manager, Daycare Manager and

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No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
					Nurse in Charge of the ward in consultation with Hospital Services Manager. Cancellations and there reasons are recorded by daycare services.
27	6.3.2	It is recommended that the ward manager ensures that patients' relatives are informed of the independent advocacy services available.	1	Immediate and ongoing	Relatives are informed of advocacy services through the ward welcome pack. Posters are also displayed in the ward and leaflets are available
28	5.3.1 (a)	It is recommended the Trust reviews the blanket restriction of locked internal doors within Moylena.	1	Immediate and ongoing	The use of any blanket restrictions in the ward has been reviewed and each individual care plan updated for each patient. Communal area doors are all open with the exception of those areas where risk s have been identified
29	5.3.1 (a)	It is recommended the ward manager ensures that care plans in relation to restrictive practices are reviewed to ensure that the rationale is based on individual risk assessments and to ensure the deprivation of liberty is proportionate and necessary to each identified risk.	1	2 October 2014	Care plans in relation to the use of restrictive practice in the ward have been reviewed. All patients are individually assessed in relation to risk and a clear rationale indicated.
30	5.3.3 (b)	It is recommended that the Trust	1	2 October	The trust will undertake a review of the restrictive

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No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
		reviews restrictive practices on the ward. This review should include the introduction of strategies to reduce the level of restriction to help prepare patients for a successful transition into the community.		2014	practices for this ward.
31	6.3.2 (b)	It is recommended that the ward manager ensures that patients and / or their relatives are involved in the decision making processes in relation to the use of restrictive practices.	1	2 December 2014	The assessment details to what level the patients representative wish to be involved in their relatives care and treatment. The assessment also indicates how and when the representative wishes to be contacted. The use of restrictive practice and the decision making process is discussed during this contact. The care plan is discussed with the patient, this includes the use of restrictive practice
32	6.3.2 (b)	It is recommended that patients and/or their representatives have the opportunity to participate in and contribute to the discharge planning process and that their attendance or otherwise is documented.	1	Immediate and ongoing	The assessment details to what level the patients representative wish to be involved in their relatives care and treatment. The assessment also indicates how and when the representative wishes to be contacted. Discharge planning is discussed during this contact. Relatives are also invited to discharge planning meetings once possible community placements have been identified. Attendance or non-attendance is recorded in the

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No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
					minutes. If relative is invited and is unable to attend a copy of the minutes is sent to them
33	5.3.3 (d)	It is recommended that the ward manager ensures that visiting professionals document their visit, and their intervention in the patients care documentation.	1	Immediate and ongoing	Visiting professionals document their visit and intervention in the clinical file.
34	5.3.3	It is recommended that the ward manager ensures each patient has a discharge pathway documented in their care plan, this should include, definitive action plans, responsible persons for their delivery and timescales.	1	Immediate and ongoing	All patients have a discharge plan in their care plan, which is appropriate to the stage they are at in the discharge process. This details a plan of action, responsible persons for their delivery and timescales. Patients going through the discharge process also have a discharge tracking template
35	8.3 (k)	It is recommended that the ward manager ensures that locally resolved complaints are recorded in line with Trust policy.	1	2 December 2014	Locally resolved complaints are recorded in line with Trust policy. A dedicated file has been set up to facilitate this.

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

NAME OF WARD MANAGER COMPLETING QIP	John morgan
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	✓		Wendy McGregor	**2 October 2014**
B.	Further information requested from provider				