The Regulation and Quality Improvement Authority

# Moylena

# Muckamore Abbey Hospital

# Belfast Health & Social Care Trust

# Unannounced Inspection Report

## Date of inspection: 20 & 21 May 2015

npm national preventive mechanism

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# Our Vision, Purpose and Values

## Vision

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

## Purpose

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

## Values

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

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

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

**Contents**

## 1.0 Introduction

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

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

**Is Care Safe?**

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

**Is Care Effective?**

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

**Is Care Compassionate?**

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

## 2.0 Purpose and Aim of this Inspection

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

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

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

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

## 2.1 What happens on inspection

**What did the inspector do:**

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

**At the end of the inspection the inspector:**

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

**After the inspection the ward staff will:**

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

## 3.0 About the ward

Moylena is a resettlement ward that provides continuing care to thirteen male patients with a learning disability who present with behaviours that challenge. Moylena also provides care and support to three patients who reside in a satellite unit, previously known as the Oldstone ward. All patients under the care of the Moylena ward are awaiting discharge into community facilities.

There were eleven patients on the ward on the days of the inspection; one patient was in an acute general hospital and one patient was on trial resettlement leave. One patient on the ward was 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. The person in charge on the days of the inspection was the ward sister.

## 4.0 Summary

Progress in implementing the recommendations made following the previous inspection carried out on 8 & 9 July 2014, were assessed during this inspection. There were a total of 35 recommendations made following the last inspections.

It was good to note that 27 recommendations had been implemented in full.

Inspectors noted that improvements had been made in relation to person centred assessments, care plans and risk assessments. Patients and their

representative had been involved in their care plans. Discharge processes and pathways were in place.

It was good to note that staff were adhering to Department of Health good practice guidance and trust policy on the management of patients who lack the capacity to consent.

The ward had developed a protocol to guide staff in the event where a patient presented with unexplained or explained marks,bruises of injuries. An improvement was noted in reporting and recording of incidents and accidents.

Eight recommendations had not been met. Two of these recommendations will be restated for a third time and six will restated for a second time following these inspections.

Inspectors noted that although a safeguarding vulnerable adult protocol had been developed, staff were not correctly completing the supporting documentation.

Inspectors were concerned that restrictive practices and blanket restrictions had not been implemented or reviewed in accordance with DHSSPS Deprivation of Liberty Safeguards (DOLS)- interim guidance (2010). Inspectors were also concerned that one patient on the ward was subject to living in a restricted area on the ward. The patient could not leave the area voluntarily as staff controlled the entry and exit. Inspectors were concerned that this practice could be viewed as secluding the patient and also could be seen as subjecting the patient to “defacto detention” as the patient was not detained. There was no evidence that the patient was choosing to be locked into this environment.

Patients in Moylena present with a range of physical health needs, complex behaviours that challenge, including self abusive behaviour that frequently causes injury and physical aggression. Patients also require support with verbal communication. It was therefore concerning that only one patient had a behaviour management plan in place and none of the patients had a communication assessment or an individualised tool to support with communication. A new recommendation has been made in relation to behaviour support.

There was limited involvement of patient and / or their representative in the completion of comprehensive risk screening tools.

Inspectors noted that not all of the patients care records had been uploaded onto the electronic recording system (PARIS). Subsequently, patients had several sets of care files. Inspectors were confused about which records were up to date and noted there was a duplication of records. A new recommendation has been made in relation to this.

The ward environment was observed to clean and well maintained. The environment appeared to be comfortable and met the needs of the patients. Easy to read information was available for patients in relation to Human Rights, how to make a complaint and advocacy services. However there was

no information available for patients to orientate them to time, place or who the staff were. A recommendation has been made.

Patients could not access their bedroom area due to a locked internal door. Exit from the ward was also locked.

Patients were observed to be at ease on the ward. Staff were attentive and caring toward patients. Staff demonstrated their knowledge and skills when supporting patients with their daily activites of living. It was good to note that staff were skilled when supporting patients presenting with behaviours that challenged.

The above concerns were discussed at the conclusion of the inspection with the ward manager and senior ward amangers. In addition to this, RQIA met with senior trust representatives and assurances were given that recommendations in relation to safeguarding vulnerable adults, restrictive practices and patient access to the multi-disciplinary team would be implemented in full.

## 4.1 Implementation of Recommendations

Fourteen recommendations which relate to the key question "**Is Care Safe**?" were made following the inspection undertaken on 8 & 9 July 2014.

These recommendations concerned the action staff took when patients presented with bruising, marks and injuries (unexplained or explained). There had been concerns about how staff were completing Promoting Quality Care risk screening tools, assessments and management plans. At the last inspection it was noted that there was no rationale in place to support the restrictive practices on the ward. Care documentation had not been completed in accordance with professional standards or in line with Trust policy.

The inspector was pleased to note that nine recommendations had been fully implemented. The ward had developed a protocol to guide staff when patients present with unexplained or explained bruising, marks and injuries. Promoting Quality Care risk screening tools were completed and signed by the multi disciplainary team. Patient finances were managed in line with trust policy. Staff had received training in Human Rights and capacity and consent. Care plans and risk assessments had been reviewed and were up to date.

However, despite assurances from the Trust, five recommendations had not been fully implemented. Staff were not correctly completing safeguarding vulnerable adult documentation correctly. Patients were subject to restrictive practices with no clear rationale recorded. There was no evidence that the trust had formally reviewed these restrictive practices. There was limited patient or representative involvement in risk assessments.

Seven recommendations which relate to the key question "**Is Care Effective**?" were made following the inspection undertaken on 8 & 9 July 2014.

These recommendations concerned indiviudalised activity assessment and activity plans, individual communication assessments and tools to support communication. There were no records maintained by other professionals who visited any of the patients. Discharge pathways had not been developed.

The inspector was pleased to note that five recommendations had been fully implemented. All patients had an activity assessment and individualised plan in place. Visiting professionals had recorded their visit and intervention with the patient. Each patient had a discharge care plan in place.

However, despite assurances from the Trust, two recommendations had not been fully implemented. Patients did not have an individualised communication assessment or tool in place to support with communication.

Fourteen recommendations which relate to the key question "**Is Care Compassionate**?" were made following the inspection undertaken on 8 & 9 July 2014

These recommendations concerned regular opportunities for patients and / or their representatives to be involved in care and treatment plans or be involved in discharge plans. Patients' capacity to consent had not been assessed in accordance with Department of Health guidance or Trust policy. Patients were subject to a number of blanket restrictions.

The inspector was pleased to note that thirteen recommendations had been fully implemented. Patients and their representatives were involved in care and treatment plans. Staff were adhering to Department of Health Reference Guide to Consent for Examination or Treatment (2009) and Trust policy in relation to on capacity and consent.

However, despite assurances from the Trust, one recommendation had not been fully implemented. The trust had not reviewed the blanket restriction of locking internal doors in Moylena.

The detailed findings in relation to follow up recommendations are included in Appendix 1

## 5.0 Ward Environment

"A physical environment that is fit for purpose delivering a relaxed, comfortable, safe and predictable environment is essential to patient recovery and can be fostered through physical surroundings." Do the right thing: How to judge a good ward. (Ten standards for adult-in-patient mental health care RCPSYCH June 2011)

The inspector and lay assessor assessed the ward's physical environment using a ward observational tool and check list.

**Summary**

The reception area in the ward was well presented and included notice boards that displayed information detailing the ward's philosophy and the patients' charter. There was also a wide range of information available which was relevant to patient/relatives. This included contact information for local support groups and human rights organisations. The ward provided an up to date patient information booklet and it was good to note that this was in easy read format.

There was information displayed in easy read format on the ward's main notice board in relation to the advocacy service, the Trust's complaints procedure, the adult safeguarding procedures and an RQIA inspection report. It was positive to note that the ward had a large amount of easy read information available for patients. This included information in relation to Human Rights, the Mental Health (Northern Ireland) Order 1986, The Mental Health Review Tribunal and patients' right to access information held about them.

The ward's environment presented as clean, clutter free and well maintained. There was good ventilation, large lounge areas and neutral odours. Ward furnishings were well maintained, comfortable and appropriate to the needs of the patient group. The ward was located over two floors. Patients' sleeping accommodation was located upstairs and lounge, kitchen and the dining area were located on the ground floor. Inspectors observed that patient access to the bedroom area was restricted during the day. The two doors leading to the bedroom area were locked. Inspectors were informed that patients could access their bedroom area upon request and with support from staff. Inspectors noted that the use of this restriction was not reflected in patient care plans. The use of restrictive practices within the ward is discussed in the main body of the report.

The ward's main rooms were located off two large corridors which extended the length of the building on both floors. Inspectors observed that there was a lack of pictorial signage to help orientate patients to the wards environment. Given that the doors were all similar in design inspectors were concerned that patients could become confused regarding their surroundings.

The room used to facilitate visits from patients' relatives' carers was located opposite the ward's main office. The room was small, cramped and inappropriate for more than two visitors at a time. Inspectors were also concerned that one of the ward's bathroom doors (door 57) lacked appropriate frosted covering resulting in patients using the bathroom not being afforded appropriate privacy. A recommendation has been made.

One patient admitted to the ward was receiving enhanced observations. Staff members providing this level of support throughout the day were observed engaging with the patient and treating them with respect and dignity. The patient was cared for in a separate area located opposite the main sleeping

area. Inspectors were concerned that the patient's care and treatment arrangements included restrictive practices that were not reflected in the patient's care records.

The inspectors identified other areas which should be reviewed by the ward manager to improve standards on the ward in accordance with good practice guidance. These include:

- Displaying information about the ward's performance e.g. information in relation to incidents, compliments and complaints.
- Details of the dates and time of ward round.
- Details about staff on duty and the patient's named and associate nurse.
- The allocated visitor's room was cramp and inappropriate to the needs of patients and their visitors.
- There was no signage to indicate bathroom, bedroom or sitting areas.

The detailed findings from the ward environment observation are included in Appendix 2

## 6.0 Observation Session

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

The inspector completed a 20 minute direct observation using the QUIS tool during the inspection and assessed whether the quality of the interaction and communication was positive, basic, neutral, or negative.

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

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

**Neutral** – brief indifferent interactions

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

## 6.1 Summary

The formal session involved observations of interactions between staff and patients/visitors throughout the first day of the inspection. Four interactions were noted in this time period. The outcome of these interactions was as follows:

| Positive | Basic | Neutral | Negative |
|---|---|---|---|
| 100% | 0% | 0% | 0% |

Inspectors observed interactions between staff and patients throughout the day of the inspection. Interactions between staff and patients were noted to be positive and respectful. Staff engaged with patients using appropriate verbal and non-verbal communication and inspectors evidenced that staff understood patient needs and responded quickly to patient requests. Inspectors witnessed staff to be attentive, observant, respectful and supportive towards patients.

One patient and a nursing assistant were observed during an outing to the hospital's café. The patient appeared relaxed and at ease with the staff member. The patient presented with behaviour that challenged and the member of staff demonstrated a high degree of skill, knowledge and competence whilst supporting the patient.

Patients on the ward appeared relaxed and at ease in their surroundings. The staff appeared to have a good level of understanding in relation to each patient's individual needs. Throughout the inspection inspectors evidenced that staff treated patients with respect and dignity. It was good to note that staff were available throughout the ward.

The detailed findings from the observation session are included in Appendix 3.

## 7.0 Patient Experience Interviews

The lay assessor and inspector met with two of the three patients who were residents in the satellite unit attached to the Moylena ward at the time of the inspection. Both patients reflected that they generally managed independently and would call on staff as and when required. Each patient reported no concerns regarding the care and treatment they received in the satellite unit. The focus of the patients conversation was centred on their pending resettlement in the community. Both patients were waiting to take ownership of their new homes and both reported that they would be leaving over the summer months. Patients comments included;

*"Can't wait to move into my new home";*

*"I have met with all the big managers in Muckamore and… finally… I am moving out";*

The atmosphere within the Moylena satellite unit was one of transition. The patients appeared to have significant independence within the unit and in the completion of their personal care and daily living tasks. The patients resided in one of the bungalows previously attached to the Oldstone ward.

Patients in the unit were supported by a staff nurse. A nurse was available 24 hours each day. The lay assessor and inspector met with the nurse. We identified no issues regarding the support, care and treatment provided to patients resident in the satellite unit.

One relative agreed to meet with the inspector to talk about the care and treatment on the ward. The relative expressed their concerns about the restrictive practices on the ward. These were addressed with the ward manager and are inclusive in the main findings in the report.

## 7.1 Other areas examined

**During the course of the inspection inspectors met with:**

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| **Ward Staff** | **One** |
| **Other ward professionals** | **Two** |
| **Advocates** | **One** |

**Ward staff** told inspectors that:
The ward had gone through a transition period of introducing a new team of staff. This had proved challenging as patients and staff got to know each other. Staff stated they enjoyed caring for the patients in Moylena.

**Other ward professionals** told inspectors that :
They had no concerns about the care and treatment patients in Moylena received. Staff stated that at times they felt the reasons patients presented with behaviours that challenge was due to the ward environment.

**The advocate** told inspector that:
They were completing a quality of life assessment for patients who were preparing for discharge. The advocate stated staff were always helpful and open and worked well together.

## 8.0 Next Steps

A Quality Improvement Plan (QIP) which details the areas identified for improvement has been sent to the ward. The Trust, in conjunction with ward staff, must complete the QIP detailing the actions to be taken to address the areas identified and return the QIP to RQIA by 16 July 2015.

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

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

**Appendix 1 – Follow up on Previous Recommendations**

**Appendix 2 – Ward Environment Observation**
**(This document can be made available on request)**

**Appendix 3 – QUIS**
**(This document can be made available on request)**

**Follow-up on recommendations made following the unannounced inspection on 8 & 9 July 2014**

| No. | Reference | Recommendation | Number of times stated | Action Taken (confirmed during this inspection) | Inspector's Validation of Compliance |
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| 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 | Inspectors reviewed care documentation in relation to five patients.<br>Each patient had an activity assessment completed as part of their person centred nursing assessment and care plan.<br>Each assessment detailed the activities that patients like to participate in.<br>Each patient had an individualised seven day activity schedule completed and included evening activities.<br>Activity schedules included attendance at Moyola day care facility.<br>Activities available and facilitated by Moylena staff included walks, foot spa, art and craft, relaxing to music etc. Patients from Moylena had access to the art room in Portmore.<br>On the days of the inspection patients were observed having a foot spa, going out for a walk and enjoying aromatherapy delivered by the hospital aroma therapist.<br>Inspectors noted that attendance and participation in activities was recorded. | Fully met |
| 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 | 2 | Inspectors reviewed the protocol and supporting documentation in place to guide staff when patients present with unexplained / explained marks, bruises etc.<br><br>Inspectors reviewed four body charts and supporting witness statements completed for two patients who presented with unexplained marks. The body charts and | Not met |

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| | | sustaining or presenting with unexplained marks, bruises etc. | | witness statements were completed between 1 May and 20 May 2015. This review evidenced that:<br>• One body chart was not completed on the correct template;<br>• One body chart template did not have a date recorded;<br>• The reason for the injury / blemish had not been confirmed or recorded on three body chart templates;<br>• One body chart had been completed by a health care assistant but had not been signed by a registrant / nurse in charge who should have reviewed the chart;<br>• One witness statement and the corresponding case notes conflicted with what was recorded on the safeguarding vulnerable adult referral form. The contents of the form did not concur with the verbal report recorded by the ward manager<br><br>This recommendation will be restated for a third time. | |
| 3 | 5.3.1 (a) | It is recommended that the ward manager ensures that risk screening tools are signed on completion | 2 | Inspectors reviewed comprehensive risk screening tools in relation to five patients.<br>All five risk screening tools had been signed by the author, the ward manager and consultant psychiatrist. | Fully met |
| 4 | 5.3.3 (b) | It was recommended that representatives of patients are provided with regular | 2 | There was evidence in the five sets of care documentation reviewed that patients representatives were informed of accidents, incidents, safeguarding vulnerable adult | Fully met |

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| | | opportunities to comment on the care and treatment available to patients on the ward and that the ward is more accessible to patients' visitors. | | referrals and any marks / bruises.<br>Inspectors noted that it was detailed in the patients care plans which family member should be contacted.<br>There was evidence in the case notes that representatives had been informed and kept up to date with any changes in the patients care<br>There was evidence of representative involvement with discharge / resettlement plans.<br>Inspectors spoke with the resettlement advocate who was involved with patients and their families. The advocate stated they work with both patients and families where agreed by the patient's family. | |
| 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 | Inspectors reviewed the ward's processes for care planning and the management of restrictive practices. Inspectors found the following:<br>• The ward manager informed inspectors that an informal review had been completed in relation to the use of locked doors. There was no evidence of a formal review.<br>• Although the main entrance/exit door was unlocked, patients could not voluntarily leave the ward as an internal door leading to the final exit door was locked. Patients could not access their bedroom area because of two locked internal doors.<br>• Three of the five restrictive practice care records reviewed stated that the patient did not require a locked environment. A further rationale recorded that there was no other suitable facility available to meet the patient's needs. Inspectors were | Not met |

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| | | | | informed the reason for the locked door was due to the staffing levels.<br>• Only one of the 12 patients on the ward had been detained in accordance with the Mental Health (Northern Ireland) Order 1986. The other 11 patients who could not leave the ward voluntarily could be considered as “de facto detained”.<br>• One restrictive practice care plan had not been updated to reflect that the patient had been regraded to voluntary admission status.<br>• One restrictive practice care plan was not updated to reflect the review of the patient’s presenting risk. The restrictive care plan was completed on 8 February 2015 and had not been updated following the review of presenting risk completed on 11 February 2015.<br>• One patient was locked into a separate part of the ward and segregated from the other patients. The patient was on enhanced observations and required continuous one to one supervision up to 2030 hours; this reduced to level two observations, review every 20 minutes, until the patient went to sleep, and the observations reduced to level two every hour once the patient was asleep. Inspectors noted it was recorded that the patient sought attention from staff by banging on a window. The rationale for this level of restriction was due to the history of unpredictable assaults of fellow patients. The patient was unable to leave their area as staff | |

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| | | | | had locked the door and it could not be opened by the patient. The ward consultant stated that it was the patient's choice to be locked into their bedroom area due to their autism and intolerance of others. However inspectors were concerned that it was unclear if or how the patient had chosen this level of restriction or that the patient's level of understanding in relation to making this choice had been assessed and appropriately recorded.<br><br>A positive behaviour support plan had been developed for this patient however it was unclear how staff were implementing this plan and there was no reference to its use in the case progress notes.<br><br>• There was no evidence that the Trust had reviewed the restrictive practices on the ward to include the introduction of strategies to reduce the level of restrictions used. Only one of the 12 patients had a behaviour management plan in place. Despite all patients on the ward displaying behaviours that challenge, including self-abusive behaviours that frequently cause injury and physical aggression. The remaining 11 patients had not been assessed by the behaviour support team to develop and implement behaviour management plans.<br><br>This recommendation will be restated for a third time | |
| 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 | 2 | From the patient care records reviewed it was noted that three patients required specific interventions (1 surgical, 1 blood glucose monitoring and 1 medical investigation). Inspectors noted that each patient's capacity to consent had been assessed. Each patient had been assessed as | Fully met |

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| | | documented | | not having capacity to consent to the interventions. A best interest pathway was completed by the multi-disciplinary team, signed by the consultant and a rationale was recorded explaining why the intervention was in the patient's best interests. | |
| 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 | Inspectors reviewed best interest documentation that had been completed for three patients. (As above)<br>There was evidence of patient's representatives had been involved in the decision.<br>Best interest decisions were made by the multi-disciplinary team.<br>The rationale recorded evidenced that the intervention was necessary, proportionate and in the patient's best interests.<br>Independent advocacy services are available on the ward.<br>There was evidence the independent advocates had been involved in best interest decisions where patient's families had agreed. | Fully met |
| 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 | Inspectors reviewed the records in relation to patient finances and noted that a record of staff who had access to the key to the Bisley drawer and the reason for access was maintained. | Fully met |
| 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 comprehensive risk assessment is agreed by the | | Inspectors reviewed risk screening tools completed in relation to five patients.<br>One of the four patients reviewed had proceeded to a comprehensive risk assessment.<br>A rationale for not proceeding to comprehensive risk assessment was recorded in the remaining four risk screening tools. | Fully met |

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| | | 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. | | The rationale recorded in the four risk screening tools stated that; “MDT discussion regarding risk factors. No need for a comprehensive risk assessment or specialised assessment to be carried out as the care plan information reflects any risks”<br>Inspectors noted that patient’s care plans addressed and managed the risks identified in the risk screening tool. | |
| 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 | From the five sets of care records reviewed by inspectors there was evidence that patient’s capacity to consent was assessed and recorded.<br>Each patient’s capacity to consent was reflected throughout the care documentation. Multi-disciplinary minutes referenced the level of understanding of each patient and what reasonable adjustments had been made to support the patient with their understanding and decision making.<br>Where patients were assessed as not having capacity to consent to specific interventions a best interest pathway was followed.<br>Each patient had a capacity assessment in relation to managing their finances completed. | Fully met |
| 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 | 1 | In the five sets of care documentation reviewed by inspectors there was evidence of patients and / or their representative involvement in formal assessments in relation to a patient’s capacity to consent.<br>This was evidenced in the minutes of the multi-disciplinary team (MDT) meeting minutes and within the patient’s case notes.<br>It was documented that the consultant had met and spoke | Fully met |

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| | | recorded in the patients care documentation. | | to patient's and had assessed and recorded their level of understanding prior to every MDT meeting.<br>Inspectors noted that each patient's level of understanding in relation to their capacity to consent to care was evidenced in the case notes reviewed from the 1 May to 21 May 2015.<br>There was evidence that patient's representatives had been kept informed and were involved in decision making in relation to care, specific interventions and resettlement processes. | |
| 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 | Inspectors noted that three of the five sets of records reviewed evidenced that patients had their capacity to consent assessed in relation to specific interventions (1 surgical, 1 blood glucose monitoring and 1 medical investigation). On these occasions inspectors noted a best interest pathway and check list had been completed by the multi-disciplinary team. This had been signed by the ward consultant as the patient was assessed as not having capacity to consent. | Fully met |
| 13 | 5.3.1 (f) | It is recommended that the ward manager ensures that staff assess patients consent to daily care activities and that this is recorded in the patient's daily progress notes. | 1 | Inspectors reviewed case notes completed from the 1 May to 21 May 2015 in relation to five patients.<br>Case notes evidenced that staff had assessed patient's capacity to consent prior to supporting patients with their daily care activities.<br>There was evidence that staff had sought patient's views before supporting them with their daily care activities.<br>Case notes referenced if patients had refused and what their preferred choices were.<br>Where patients had refused or were assessed as not | Fully met |

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| | | | | having capacity to consent to a care activity there was a record of continual monitoring by staff and where appropriate a best interest pathway was followed e.g blood glucose monitoring. | |
| 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 | Training records evidenced that 15 out of 34 staff had attended human rights training.<br>Inspectors were informed by the nurse development lead that training dates had just been released and the remaining staff have been booked onto the training. | Fully met |
| 15 | 5.3.1 (f) | It is recommended that the ward manager ensures that all staff attend training on capacity to consent. | 1 | Training records reviewed evidenced that 15 out of 34 staff had attended training human rights.<br>Inspectors were informed by the nurse development lead that training dates had just been released and the remaining staff have been booked onto the training. | Fully met |
| 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 | In the five sets of care documentation reviewed there was evidence that patients and their representatives had been given the opportunity to contribute in the development of patient's care plans.<br>It was documented in the MDT meeting minutes that the ward consultant had met with each patient and discussed their care plan and the patient's level of understanding was recorded. There was evidence in the patient's case notes that care plans had been discussed with representatives and that they had been kept up to date with any changes. | Fully met |
| 17 | 5.3.1 (a) | It is recommended that the ward manager ensures that all patients who require support with communication | 1 | Inspectors noted on reviewing the care documentation, from their meetings with patients and through speaking to staff that patients in Moylena presented with a range of complex physical needs and behaviours and require | Not met |

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| | | have a communication assessment completed. | | support with communication.<br>There was no evidence that patients' had a comprehensive and holistic communication assessment had been completed by speech and language therapy (SALT). There was evidence that all patients had been referred to SALT for a communication assessment in March 2015. However, despite RQIA making this recommendation in July 2014 there have been no SALT assessments completed with patients. | |
| 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 | Each set of patient care records reviewed evidenced that patients had a communication passport completed.<br>Inspectors were informed that nursing staff had completed the passport.<br>The communication passport detailed the following;<br>Patients likes and dislikes;<br>Patients level of understanding e.g. can understand phrases with 1 – 2 ideas;<br>How patients communicate e.g. with speech / words, body language, facial expression;<br>What the patient communicates e.g. wants, feelings;<br>What is needed to help the patient understand e.g. give me time to think, remind me to listen, don't stand close to me.<br><br>However without a comprehensive communication assessment completed it was unclear if the communication passport was the best and most appropriate communication tool for each individual patient. Although each passport was individual to the patient, the same tool was used for all patients regardless of the different and complex needs of the patients in Moylena. | Not met |

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| | | | | Two patients had a communication dictionary completed by nursing staff that included; what patient says, what the patient means, how staff should respond.<br><br>Patients had been referred to SALT for communication assessments. However, assessments had not been completed and inspectors were concerned that an opportunity to support patients with their communication needs was being missed. This recommendation will be restated for a second time. | |
| 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 | Inspectors were informed by the ward manager that consideration had been given to developing a tool similar to the communication dictionary. Following this the communication dictionary was implemented with another patient. | Fully met |
| 20 | 5.3.1 (a) | It is recommended that the ward manager reviews and signs the risk screening tool on completion as per Promoting Quality Care Good Practice Guidance on the Assessment and Management of Risk in | 1 | Inspectors reviewed five promoting quality care risk screening risk screening tools and one comprehensive risk assessment.<br>The ward manager had reviewed and signed each comprehensive risk screening tool on completion. | Fully met |

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| | | 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 | Inspectors reviewed five risk screening tools and noted the following;<br>There was evidence of patient representative involvement and signature in one risk screening tool and patient involvement and signature in another.<br>However there was no evidence in three risk screening tools of patient and / or representative involvement or a rationale recorded for the reason.<br>This recommendation will be rested for a second time. | Not met |
| 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 | Since the last inspection in July 2014 a protocol had been developed to guide staff when patients present with explained / unexplained marks, bruising, injuries etc.<br>Inspectors reviewed the protocol and supporting documentation.<br>Inspectors also spoke with the designated vulnerable adult officer.<br>It was noted in the evidence reviewed that staff followed the protocol and had consulted with the designated officer.<br>Following discussion the designated officer agrees whether a safeguarding referral is required.<br>This was documented in the patient's case notes on the PARIS system. | Fully met |
| 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 | Inspectors noted in the five sets of care documentation that patients care plans and risk assessments had been reviewed and updated following incidents or accidents.<br>Each patient had an up to date assessment for eating and drinking, nutrition and moving and handling.<br>Following a fall each patient had a post falls assessment | Fully met |

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| | | | | completed, and the risk assessment and care plan were updated. | |
| 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 | Inspectors reviewed case notes in relation to five patients There was evidence that patient's representatives had been informed of any incidents / accidents involving a patient.<br>Inspectors reviewed the incident reporting electronic system (DATIX). The system signposts staff to inform relatives of any incidents.<br>There was evidence that staff also informed patients' representative when a safeguarding vulnerable adult referral had been made. | Fully met |
| 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 | In the five sets of care documentation reviewed there was evidence that patient's representatives had been involved in the patient's recreational and therapeutic assessments and activity plans. It was recorded that patient's representatives had been asked about their relative's choices, likes and dislikes in relation to activities and social outings. | Fully met |
| 26 | 6.3.1 | It is recommended that the Trust ensures that patients scheduled day-care is not cancelled due to staff shortages. | 1 | Inspectors did not see any evidence during the inspection that patient's scheduled day had been cancelled.<br>On the day of the inspection patients were observed attending their planned day care session.<br>Inspectors could not find any evidence that patients daily routine was effected by staff shortages | Fully met |
| 27 | 6.3.2 | It is recommended that the ward manager ensures that patients' relatives are informed of the independent advocacy services available. | 1 | Inspectors noted information in relation to the independent advocacy services was displayed in the entrance area to the ward.<br>Inspectors spoke to an independent advocate. The advocate confirmed that patient's relatives were informed | Fully met |

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| | | | | of independent advocacy services. The advocate stated that some families choose not to have advocacy involvement. | |
| 28 | 5.3.1 (a) | It is recommended the Trust reviews the blanket restriction of locked internal doors within Moylena. | 1 | The ward manager informed inspectors that an informal review had been completed in relation to the use of locked doors. There was no evidence of a formal review.<br>Although the main entrance/exit door was unlocked, patients could not voluntarily leave the ward as an internal door leading to the final exit door was locked. Patients could not access their bedroom area because of two locked internal doors. The ward manager stated that although they have the required quota to maintain the safety of the patients they do not have the required quota of staff to deliver the philosophy of care and treatment on the ward as the external door remains locked.<br>The remainder of the internal doors were open, including the door to the garden area.<br>This recommendation will be restated for a second time. | Not met |
| 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 | Inspectors reviewed care plans in relation to restrictions for five patients.<br>Each patient had an individualised restrictive practice care plan completed.<br>However it was recorded in three of the five restrictive care plans that the patient did not require a locked environment and therefore in keeping with the Deprivation of Liberty – interim guidance (2010) that this restriction was not proportionate or necessary. The rationale for each patient remaining behind a locked door recorded that there was no other suitable facility available, for the patient, on site.<br><br>Inspectors noted that one patient who had been | Not met |

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| | | | | transferred from another ward had not been reviewed since their admission as their care documentation, including their restrictive care plans, had not been updated to reflect that the patient had been regraded to a voluntary status.<br>This recommendation will be restated for a second time. | |
| 30 | 5.3.3 (b) | It is recommended that the 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. | 1 | There was no evidence that the Trust had reviewed the use of restrictive practices on the ward to include the introduction of strategies to reduce the level of restriction. Only one of the 12 patients had a behaviour management plan in place. Despite all patients on the ward displaying behaviours that challenge, including self-abusive behaviours that frequently cause injury and physical aggression, the remaining 11 patients had not been assessed by the behaviour support team to develop and implement behaviour management plans.<br>This recommendation will be restated for a second time. | Not met |
| 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 | In the five sets of care documentation reviewed inspectors noted that one patient had been involved in decision making process in relation to the use of restrictive practices.<br>There was evidence in the four remaining sets of care documentation of patient representative involvement. Information in relation to restrictive practices was available in the ward information booklet. | Fully met |
| 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 | 1 | There was evidence in the five sets of care documentation reviewed that patient's representatives had been offered the opportunity to be involved in, and had contributed to, the patient's discharge planning process. This was evidenced in the discharge planning meetings and in patient's care plans. There was also evidence of in reach involvement from potential community service providers. | Fully met |

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| | | otherwise is documented. | | Inspectors met with three patients who confirmed that they had been fully involved in the discharge process.<br>The independent advocate confirmed that patient representatives were involved in the discharge process. | |
| 33 | 5.3.3(d) | It is recommended that the ward manager ensures visiting professionals document their visit, and their intervention in the patients care documentation. | 1 | Records reviewed by inspectors evidenced that all visiting professionals had documented their visit and their intervention in the patient's electronic records.<br>Day care staff had also recorded in the electronic records. | Fully met |
| 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 | Inspectors reviewed discharge planning records in relation to five patients.<br>Each patient had a discharge pathway completed.<br>Inspectors reviewed the minutes of resettlement meetings and noted that action plans and the responsible persons for their delivery and timescales had been agreed.<br>There was evidence of patient representative involvement in each patients discharge planning process. | Fully met |
| 35 | 8.3 (k) | It is recommended that the ward manager ensures that locally resolved complaints are recorded in line with trust policy | 1 | Information in relation to complaints was available for patients, their representatives and staff.<br>Inspectors noted a file was maintained for locally resolved complaints. There were no complaints recorded. The ward manager stated there have been no complaints. | Fully met |

A completed Quality Improvement Plan from the inspection of this service has not yet been returned.

If you have any further enquiries regarding this report please contact RQIA through the e-mail address info@rqia.org.uk

# Quality Improvement Plan

# Unannounced Inspection

# Moylena, Muckamore Abbey Hospital

# 20 & 21 May 2015

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

The specific actions set out in the Quality Improvement Plan were discussed with the ward manager and senior hospital managers 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 |
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| **Is Care Safe?** | | | | | |
| 1 | 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. | 3 | Immediate and ongoing | |
| 2 | 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. | 3 | Immediate and ongoing | |
| 3 | 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 | 2 | 18 July 2015 | |

**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 |
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| | | when this is not possible. | | | |
| 4 | 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. | 2 | 18 September 2015 | |
| 5 | 5.3.3 (b) | It is recommended that the 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. | 2 | 18 September 2015 | |
| 6 | 5.3.1 (a) | It is recommended that the trust ensures that patients' records have been uploaded onto the electronic care record system (PARIS). A system should be introduced for records that cannot be uploaded on to the PARIS | 1 | 18 August 2015 | |

**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 |
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| | | system. | | | |
| **Is Care Effective?** | | | | | |
| 7 | 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. | 2 | 18 September 2015 | |
| 8 | 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. | 2 | 18 October 2015 | |
| 9 | 5.3.1 (a) | It is recommended that the ward manager ensures that patients who present with behaviours that challenge have a behaviour assessment completed and following this an appropriate behaviour management plan is developed and implemented. | 1 | 18 October 2015 | |

**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 |
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| **Is Care Compassionate?** | | | | | |
| 10 | 5.3.1 (a) | It is recommended the Trust reviews the blanket restriction of locked internal doors within Moylena. | 2 | Immediate and ongoing | |
| 11 | 6.3.2 (a) | It is recommended that the ward manager ensures the frosted covering on the bathroom door 57 sufficiently affords patients privacy and dignity. | 1 | Immediate and ongoing | |

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

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| **NAME OF WARD MANAGER COMPLETING QIP** | |
| **NAME OF CHIEF EXECUTIVE / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP** | |

| **Inspector assessment of returned QIP** | | | | **Inspector** | **Date** |
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| | | **Yes** | **No** | | |
| A. | Quality Improvement Plan response assessed by inspector as acceptable | | | | |
| B. | Further information requested from provider | | | | |