The Regulation and Quality Improvement Authority

RQIA

Mental Health and Learning Disability

Unannounced Inspection

Six Mile Ward, Muckamore Abbey Hospital >

Belfast Health and Social Care Trust

14 and 15 January 2015

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1.0 General Information

Ward Name	Six Mile Ward, Muckamore Abbey Hospital
Trust	Belfast Health and Social Care Trust
Hospital Address	1 Abbey Road Muckamore BT41 4SH
Ward Telephone number	028 9446 3333
Ward Manager	Dessie McAuley
Email address	dessie.mcauley@belfasttrust.hscni.net
Person in charge on day of inspection	Dessie McAuley
Category of Care	Intellectual disability
Date of last inspection and inspection type	7 and 8 May 2014, patient experience interview inspection
Name of inspector(s)	Alan Guthrie

2.0 Ward profile

Six Mile ward is the regional low secure unit providing treatment and care for male patients who have an intellectual disability and have had previous contact with forensic services. At the time of the inspection the ward was providing care and treatment to 19 patients and 12 of the patients were admitted in accordance to the Mental Health (Northern Ireland) Order 1986. One patient was on leave as part of their resettlement programme.

The ward was separated into two units. Five patients were receiving treatment and care in the ward's assessment unit had 14 patients were being cared for in the wards the treatment unit. Patients on the ward were supported by a multi-disciplinary team including; nursing staff, a consultant psychiatrist, a psychologist, a social worker, the assistant day services manager, an occupational therapist and a behavioural therapist.

3.0 Introduction

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of Northern Ireland's health and social care services. RQIA was established under the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, to drive improvements for everyone using health and social care services. Additionally, RQIA is designated as one of the four Northern Ireland bodies that form part of the UK's National Preventive Mechanism (NPM). RQIA undertake a programme of regular visits to places of detention in order to prevent torture and other cruel, inhuman or degrading treatment or punishment, upholding the organisation's commitment to the United Nations Optional Protocol to the Convention Against Torture (OPCAT)**.**

3.1 Purpose and Aim of the Inspection

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

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

- The Mental Health (Northern Ireland) Order 1986;
- The Quality Standards for Health & Social Care: Supporting Good Governance and Best Practice in the HPSS, 2006
- The Human Rights Act 1998;
- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003;
- Optional Protocol to the Convention Against Torture (OPCAT) 2002.

Other published standards which guide best practice may also be referenced during the inspection process.

3.2 Methodology

RQIA has developed an approach which uses self-assessment, a critical tool for learning, as a method for preliminary assessment of achievement of the inspection standards.

Prior to the inspection RQIA forwarded the associated inspection documentation to the Trust, which allowed the ward the opportunity to demonstrate its ability to deliver a service against best practice indicators. This included the assessment of the Trust's performance against an RQIA Compliance Scale, as outlined in Section 6.

The inspection process has three key parts; self-assessment, pre-inspection analysis and the visit undertaken by the inspector.
Specific methods/processes used in this inspection include the following:

- analysis of pre-inspection information;
- discussion with patients and/or representatives;
- discussion with multi-disciplinary staff and managers;
- examination of records;
- consultation with stakeholders;
- file audit; and
- evaluation and feedback.

Any other information received by RQIA about this service and the service delivery has also been considered by the inspector in preparing for this inspection.

The recommendations made during previous inspections were also assessed during this inspection to determine the Trust's progress towards compliance. A summary of these findings are included in section 4.0, and full details of these findings are included in Appendix 1.

An overall summary of the ward's performance against the human rights theme of Autonomy is in Section 5.0 and full details of the inspection findings are included in Appendix 2.

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

4.0 Review of action plans/progress

An unannounced inspection of Six Mile ward was undertaken on 14 and 15 January 2015.

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

The recommendations made following the last announced inspection on 29 and 30 October 2013 were evaluated. The inspector was pleased to note that all nine of the recommendations had been fully met and compliance had been achieved in the following areas:

- the Trust had reviewed the ethos, function and purpose of the ward;
- discharge plans for voluntary patients remained under continuous review;
- the multi-disciplinary team (MDT) had agreed a format for conducting review meetings and this included the rotating of each meeting's chairperson and minute taker;
- the MDT had reviewed the use of restrictive practices with voluntary patients and implemented a least restrictive practice ethos;
- the Trust's observation policy had been updated;
- the Trust's procedures for handling patients' property had been updated;
- all staff had completed mandatory training in accordance to Trust policy;
- the ward's patient/staff forum was being held on a regular basis;
- the Trust had reviewed the availability of accommodation within the hospital site that might be utilised as a step down facility for voluntary patients.

4.2 Review of action plans/progress to address outcomes from the patient experience interview inspection

The recommendation made following the patient experience interview inspection on 7 and 8 May 2014 was evaluated. The inspector was pleased to note that the recommendation had been fully met and compliance had been achieved in the following area:

- the hospital's senior management team had reviewed the therapeutic wages initiative and informed RQIA of the outcome of their review. The Trust had introduced a new policy.

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

The recommendation made following the finance inspection on 31 December 2013 was evaluated. The inspector was pleased to note that the

recommendation had been fully met and compliance had been achieved in the following area:

- the ward manager had ensured that a record of staff who accessed the key to the bisley drawer, including an explanation as to the reason for access, had been maintained.

4.4 Review of implementation of any recommendations made following the investigation of a Serious Adverse Incident

A serious adverse incident had occurred on this ward on 2 July 2014**.** Relevant recommendations made by the review team who investigated the incident were evaluated during this inspection. It was good to note that compliance had been achieved in relation to:

- the implementation of recommended care arrangements to support the patient;
- appropriate care and treatment interventions relevant to the patient's needs had been agreed and implemented. The patient's care and treatment arrangements remained under continuous review.

4.5 Review of implementation of any recommendations made following the investigation of a Serious Adverse Incident

A serious adverse incident had occurred on this ward on 17 October 2014**.** Relevant recommendations made by the review team who investigated the incident were evaluated during this inspection. It was good to note that compliance had been achieved in relation to:

- the convening of a multi-agency meeting when a patient has absconded from the ward for more than two days;
- the prompt completion of patient records when an absconding incident has occurred.

Details of the above findings are included in Appendix 1.

5.0 Inspection Summary

Since the last inspection the ward has addressed a number of previous recommendations and implemented a number of positive changes. This included reviewing the restrictions used on the ward and assessing the impact restrictive practices have on voluntary patients. It was positive to note that the ward's review involved revisiting each patient's discharge plan and providing each patient with an up to date use of restrictive practice care plan. The inspector also evidenced that the Trust policies in relation to patient's finances and patient observations had been updated and that the patient/staff forum had been held on a regular basis.

During the inspection the inspector witnessed that the atmosphere in the ward was relaxed and patients presented as being comfortable and at ease in their

surroundings. Patients who met with the inspector were complimentary regarding their experience of care and treatment and they reflected positively on their relationships with ward staff. Nine patients reported having been involved in decisions regarding their care and treatment and all of the patients explained that they understood the reason why they were in hospital. One patient informed the inspector that they had not been given the opportunity to be involved in their assessment and care plan. The inspector reviewed this patient's care records and these evidenced that ward staff had consulted the patient on a continuous basis.

The inspector reviewed five sets of patient care documentation and noted that the Trust was transferring a number of patient care records onto the Trust's electronic PARIS patient information system. The inspector was informed that the system would reduce the need for the ward to retain paper records and the system would also help to ensure that patients' care records were accessible to all staff involved in the patient's care and treatment. Records reviewed by the inspector were noted to be comprehensive, specific to the individual needs of the patient and reviewed on a regular basis. It was good to note that patient signatures were evident in all the files reviewed. However, the inspector noted that two of the care plans reviewed had not been signed by the patient. A recommendation has been made.

Patients' care records included a comprehensive risk assessment, a nursing assessment, a medical assessment, a care plan and a use of restrictive practices assessment. Patients had also been provided with an assessment of their capacity to consent to treatment and a physical health assessment. Capacity assessments included a review of a patient's ability to manage their finances. It was good to note that ward staff and the ward's multi-disciplinary team continually reviewed each patient's capacity to consent and that patients' were continually involved in decision making regarding their care.

Each patient's physical health assessment included a falls risk assessment, a malnutrition universal screening tool (MUST) assessment and an adult pressure ulcer assessment. The inspector noted that nursing staff had completed these assessments with patients upon admission and reviews of patient progress were held on a regular basis. However, the frequency of reviews of patients' circumstances in relation to the MUST and ulcer assessments was not in keeping with the guidance as detailed within each of the assessment tools. The inspector discussed the use of MUST and ulcer assessments with nursing staff, the ward manager and members of the senior management team. Staff explained that patients on Six mile ward had not been admitted to the ward due to physical health care needs and the recommended frequency of MUST and ulcer assessments, as detailed on each tool, was not clinically necessary. A recommendation has been made.

Patient involvement in therapeutic and recreational activities was recorded in a personalised activity plan within each patient's file. Patients could access a range of activities on the ward and within and outside the hospital site. Ward based activities included use of the ward's gym and resource room, film nights and arts and craft sessions. The ward's psychologist, behaviour therapist,

forensic practitioner and occupational therapist provided therapeutic interventions on a one to one basis and in groups. Patients could access a range of psychotherapeutic interventions including a daily mindfulness group, dialectical behaviour therapy (DBT), group skills and one to one psychological interventions in accordance to patient need. The hospital's day care and horticultural departments provided each patient with five four hour sessions Monday to Friday. Patients could participate in a wide range of skills and activity based interventions within the hospitals day centre and it was positive to note that day care staff provided the same level of support to patients who were ward based.

Patients who met with the inspector reflected positively on their involvement in activities. Patients informed the inspector that they attended horse riding, shopping trips, football training, swimming sessions and various trips organised outside the hospital. Patients could also access the ward's gardens. The inspector noted that the garden on the treatment side of the ward was untidy as evidenced by the presence of a large amount of cigarette debris, a lack of plants and bare patches on the garden's lawn area. The inspector discussed this with the ward manager and the hospital's operation manager. Both staff had taken appropriate steps to help maintain the ward's gardens and plans to update and refurbish the garden areas had been finalised. The inspector was informed that the plans had not been implemented due to other resourcing priorities. A recommendation has been made.

The ward provided patients with a wide range of relevant information in easy to read format. The ward's welcome pack contained information regarding the ward's routine and patient's rights. Patients admitted to the ward in accordance to the Mental Health (Northern Ireland) Order 1986 could access information regarding their rights under the order. This included the patient's right to have their admission to hospital reviewed by the mental health review tribunal service. Patients who met with the inspector reported no concerns regarding their ability to access information. Patients explained that the ward staff and the advocacy service would provide information and support as required. Each of the patients who met with the inspector demonstrated understanding of the role of the ward's advocacy service and seven patients informed the inspector that they met with their advocate on a regular basis.

The inspector reviewed the ward's use of restrictive practices. The ward implemented a number of blanket restrictions to ensure patient safety and to help oversee its function as the regional low secure unit for the patient group. Blanket restrictions included the use of locked internal and external doors, restrictions on personal items, access to mobile phones, access to time off the ward (for voluntary patients), searches being carried out and restrictions regarding access to lighters and matches. The inspector reviewed how the ward implemented the restrictions and noted that a restrictive practice assessment and care plan had been completed for each patient. The care plan recorded the individual needs of each patient and the rationale for the use of restrictive practices with the patient. Restrictive practice care plans reviewed by the inspector were up to date, comprehensive and completed in

accordance to regional and Trust guidance. The inspector noted that the seven patients who were admitted to the ward on a voluntary basis were also subject to blanket restrictions. The inspector met with four of the patients. Each of the patients informed the inspector that they had consented to the use of blanket restrictions and they understood their right to leave the ward at any time.

The inspector examined the ward's procedures for managing the use of physical intervention and observations with patients. The inspector noted the use of physical intervention within the ward was managed in accordance to regional and Trust policy. This included the completion of appropriate records and the provision of quarterly reports completed by the Trust's managing actual and potential aggression (MAPA) team. Staff training records detailed that all staff had completed up to date MAPA training.

The inspector met with one patient who was receiving 1:1 observations. The patient reported no concerns regarding the management of their observations told the inspector that they felt staff were "good" at managing observations. The inspector reviewed the patient's care records and noted that the use of observations had been based on a clear rationale and completed in accordance to Trust standards. The inspector also evidenced that the patient's circumstances and the continuing need for 1:1 observations was being regularly reviewed by the ward's multi-disciplinary team.

Patient care documentation reviewed by the inspector evidenced that a discharge plan had been considered for each patient in accordance to the patient's care and treatment needs. Discharge planning was discussed with patients upon admission and reviewed weekly by the multi-disciplinary team. All of the patients who met with the inspector reflected awareness of their treatment and care plan including working towards the goal of resettlement within their respective communities. Seven patients on the ward had had their discharge delayed as a result of difficulties accessing the required community resources to meet their individual needs. Each patient's circumstances had been reported to the Health and Social Care Board.

Details of the above findings are included in Appendix 2.

On this occasion the Six mile ward has achieved an overall compliance level of compliant in relation to the Human Rights inspection theme of "Autonomy".

6.0 Consultation processes

During the course of the inspection, the inspector was able to meet with:

Patients	ten
Ward Staff	seven
Relatives	none
Other Ward Professionals	three
Advocates	none

Patients

Patients who met with the inspector were complimentary regarding the care and treatment they had received on the ward. Patients were also positive about their relationships with staff and their ability to access staff support when required. One patient informed the inspector that they had not been given the opportunity to be involved in their treatment and care. The inspector reviewed the patient's care documentation and noted that staff had continually liaised with the patient and had kept the patient informed regarding treatment and care issues.

Patients reported no concerns regarding their ability to access activities and all of the patients informed the inspector that they felt safe on the ward. Patient comments included:

"I can see the doctor whenever I want";

"Staff were all right with me";

"Staff treat me brilliant";

"Staff treat me well, they are supportive…there when I need them";

"Staff listen to me …but don't do anything…don't give me answers";

"It's all right in here…staff look after me";

"I get one to one with the psychologist…I'm doing well…I also completed the DBT course with the forensic nurse and I'm doing mindfulness classes every day except Saturday";

"Staff are very good…very helpful and understanding";

“I’m moving on this year…I feel good about this”;

“I was concerned about bullying. I spoke to staff about this and they sorted it”;

“Staff treat me well and fair…staff retiring will be missed”;

“Wards dead on; staff are good”;

“Brilliant support from the ward…nothing bad to say about it”.

Relatives/Carers

No relatives or carers were available to meet with the inspector during the inspection.

Ward Staff

The inspector met with seven members of the ward’s multi-disciplinary team (MDT). Each member of the MDT reflected that they felt the team was effective, supportive and patient focussed. Nursing staff reported feeling that the ward was well run and supervision and training were delivered in accordance to Trust and professional standards. Nursing staff also relayed feeling that their opinion was valued by other members of the MDT. The consultant psychiatrist reflected that the ward was focussed on supporting patients in their resettlement back to their locality Trust. The consultant psychiatrist reflected that they felt the MDT was “very good” and the ward promoted a progressive and positive environment for patients. The consultant also highlighted that they felt the team worked well together. However, the consultant was concerned that six patients within the ward had had their discharge from the ward delayed. This was due to issues relating to the availability of suitable community placements and the complexity of each patient’s individual treatment and care needs.

The ward’s occupational therapist (OT) informed the inspector that they found the multi-disciplinary team (MDT) to be supportive and the team had “embraced” occupational therapy as part of the ward’s core service provision. The OT stated that MDT staff referred patients as required and there was good communication between the ward and the OT service. The ward’s consultant forensic/clinical psychologist and senior social worker recorded similar experiences reporting that they felt their respective services were valued, integral to the team and supportive of the ward’s philosophy of promoting and enabling patients to recover.

Staff comments included:

“Very good multi-disciplinary team. I love working with this team”;

“This is an innovative ward where people are prepared to look at things differently”;

“Staff are good at managing vulnerable adult concerns”;

“This is a good staff team who are open, alert and committed to patients”;

“Good professional relationships and the team provide an open forum for discussion and debate”;

“My colleagues and the managers are very approachable and supportive”;

“When I first started I was made to feel welcome on the ward”.

Other Ward Professionals

The inspector met with three other ward professionals including a specialist nurse, the hospital’s safeguarding officer and the assistant day services manager. Each member of staff reflected positively on their experience of the ward. Staff informed the inspector that they felt patients on Six mile were well cared for and the staff team were motivated and patient centred.

Advocates

None of the ward’s advocates were available to meet with the inspector during the inspection.

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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	3
Other Ward Professionals	5	3
Relatives/carers	19	6

Ward Staff

The ward’s consultant forensic/clinical psychologist, the senior social worker and the forensic practitioner returned questionnaires prior to the inspection. Each member of ward staff reported awareness of the restrictive practices used within the ward and two of the staff indicted that they had received training in relation to restrictive practice. Staff listed restrictive practices to include: the use of locked doors, observations, physical interventions, restrictions on certain items, controlled access to the ward and use of the Mental Health (Northern Ireland) Order 1986. Staff reported that they felt the ward provided relevant information to patients in a format appropriate to each patient’s individual needs. Staff also recorded that each patient’s individual

therapeutic and activity needs were considered and appropriately addressed. Additional comments provided on the questionnaires included:

“Some patients choose not to access therapeutic interventions”;

“Care standards appear to be of high quality. Patients have access to the latest forensic interventions, delivered in a person focussed way”;

“A psychology post with the hospital remains vacant. This means the psychologist in post is trying to cover the rest of the hospital resulting in less focus on forensic patients and development of therapeutic services”.

Other Ward Professionals

Prior to the inspection questionnaires were received from the hospital’s safeguarding officer, a specialist nurse and an independent advocate. Each member of staff recorded that they had received training in relation to patient capacity and consent. Staff also reported that they had awareness of the deprivation of liberty safeguards (DOLS) guidance and of the restrictive practices used within the ward. Each questionnaire detailed that staff felt patients’ communication needs, patient access to information regarding their rights and access to advocacy services had been appropriately addressed within the ward. Additional comments provided on the questionnaires included:

“In a very challenging ward staff continue to manage the identified risks and empower the patients to develop and engage in positive therapeutic activities”;

“To date none of the patients have complained about care on the ward. The staff are highly trained and this is reflected in the care and service provided. I am welcome (to the ward) at any time announced or unannounced and kept fully informed of meetings, issues etc”.

Relatives/carers

Six questionnaires were returned by relatives prior to the inspection. Three relatives commented that they felt that the treatment of patients on the ward was good or excellent; two stated it required improvement and one relative relayed they felt it was poor. Four relatives recorded that they felt they had been offered the opportunity to be involved in decisions in relation to the care and treatment of patients. Two relatives stated that they had not been involved. One of the relatives explained that the patient’s social worker kept them updated regarding the patient’s progress. All of the relatives indicated that the patient had an individual assessment completed in relation to therapeutic and recreational activity. Five relatives recorded that the patient had received information in a format appropriate to the patient’s needs. Relative’s comments on the questionnaires included:

“I am a bit disappointed in the length of time (patient) has been in the ward”;

“I am only contacted by staff on the ward and (patient’s) solicitor”.

7.0 Additional matters examined/additional concerns noted

No additional matters were examined/additional concerns noted during the inspection.

Complaints

The inspector reviewed complaints received by the ward between the 1 April 2013 and the 31 March 2014. Five complaints had been received during this period. Four complaints were received from patients and one complaint had been received from a relative. Two of the complaints from service users related to care practice. One complaint had been resolved to the partial satisfaction of the patient and one had not been resolved to the satisfaction of the patient. The three remaining complaints related to issues other than care practice, environmental, finances, staff attitude and food. Two of the complaints had noted the complainant was fully satisfied with the ward’s response, including the complaint made by a relative, and the outcome of one complaint had resulted in the patient being partially satisfied with the response.

The inspector found the ward’s complaint procedure to be in accordance with the Trust’s policy and procedure. The inspector noted that information relating to the complaints procedure was available to patients and their carer/relatives.

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 Previous Recommendations

The details of follow up on previously made recommendations contained within this report are an electronic copy. If you require a hard copy of this information please contact the RQIA Mental Health and Learning Disability Team:

Appendix 2 – Inspection Findings

The Inspection Findings contained within this report is an electronic copy. If you require a hard copy of this information please contact the RQIA Mental Health and Learning Disability Team:

Contact Details
Telephone: 028 90517500
Email: Team.MentalHealth@rqia.org.uk

Follow-up on recommendations made following the announced inspection on 29 and 30 October 2013

No.	Reference.	Recommendations	Number of times stated	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	Section 6.3.1(a)	It is recommended that the Trust ensures that the ethos, function and purpose of the Six Mile Treatment Unit is reviewed.	1	Staff and senior managers who met with the inspector reported that the ethos, function and purpose of the Six Mile Treatment Unit had been reviewed. The ward is the regional low secure unit providing care and treatment to patients with an intellectual disability who have had previous contact with the criminal justice system. The inspector noted that during the inspection 14 patients were admitted to the ward. Seven of the patients had been admitted in accordance to the Mental Health (Northern Ireland) Order 1986 and seven patients were admitted on a voluntary basis. The inspector met with seven patients admitted to the treatment side of the ward. Patients who met with the inspector relayed that they understood why they were in hospital and they knew the purpose of the ward. The inspector was concerned that seven patients had been assessed as ready to be discharged from the ward and six patients discharge had been delayed. One patient was completing a resettlement programme. The inspector reviewed the circumstances of the patients whose discharge had been delayed. The inspector noted that each patient had a discharge plan and the plan was being continually reviewed by the ward's multi-disciplinary team (MDT) and the patient's local Trust. The inspector also evidenced that the MDT and the Trust continued to review the care and treatment provided on the ward in accordance to the assessed needs of patients.	Fully Met

2	Section 5.3.1(a)	It is recommended that the resettlement officer review the discharge plans for voluntary patients. The review should detail what arrangements have been agreed regarding resettlement and the reasons why resettlement has been delayed.	1	The inspector met with four patients who were admitted to the ward on a voluntary basis and reviewed five sets of patient care records. Patients who met with the inspector reported that they had been involved in their care and treatment plan and were working towards their discharge from the ward. Patient care records examined by the inspector evidenced that each patients discharge plan was continually reviewed with the patient by the multi-disciplinary team in partnership with the patient's local Trust. The inspector reviewed the care records of two patients whose discharge from the ward had been delayed. The inspector noted that the reason(s) why the patient's discharge had been delayed were recorded. The inspector evidenced that each patient's discharge plan had been reviewed on a regular basis and changes to patient's resettlement plans had been made in an attempt to address presenting difficulties and challenges that were negatively impacting on the patient's resettlement.	Fully Met
3	Section 5.3.1(a)	It is recommended that the multi-disciplinary team (MDT) review the MDT meeting record proforma and agree its format.	1	The multi-disciplinary team (MDT) had reviewed the MDT meeting record proforma and agreed its format. The inspector was informed that the team met on a weekly basis and meeting records had recently been transferred from paper copy onto electronic format. The inspector met with all the staff from the MDT. It was good to note that each member of staff reflected positively on the management of the MDT meetings and that the chairing and recording of the meeting was rotated all staff taking their turn.	Fully Met
4	Section 5.3.1(c)	It is recommended that the multi-disciplinary team	1	The use of restrictive practices with each patient was reviewed by the multi-disciplinary team on a weekly basis	Fully Met

		reviews the use of restrictive practices with voluntary patients to ensure that the least restrictive measure to safeguard individual patients is in place		and as required. Four of patients admitted to the ward on a voluntary basis met with the inspector. The inspector discussed the use of locked doors and restrictions regarding the use of mobile phones and lighters with each patient. Patients reported that they understood why the restrictions were implemented and staff had discussed this with them. Patients also reflected they had agreed to the use of the restrictions. The inspector reviewed five sets of patient care records and noted that each record contained an individualised restrictive practice care plan. The plan detailed the restrictions used with the patient, the rationale for the use of the restriction and the impact the restriction had on the patient's rights. Restrictive care plans reviewed by the inspector were noted to have been signed by the patient. The inspector was informed that the use of restrictive practices with each patient was reviewed on a weekly basis by the multi-disciplinary team (MDT). An MDT meeting record was completed for each patient and included a section entitled 'restrictive practice review'.	
5	Section 5.3.1(f)	It is recommended that the Trust updates the observation policy and procedure.	1	The inspector reviewed the Trust's observation policy which was available to each member of staff on the Trust's shared policy database. The policy had been approved in August 2013, was operational from March 2014 and is due for review in November 2016.	Fully Met
6	Section 5.3.1(c)	It is recommended that the Trust updates the policy and procedures for handling patients' property.	1	The inspector reviewed the Trust's 'Patients' Finances and Private Property-Policy for Inpatients within Mental Health and Learning Disability Hospitals. The policy had been approved in September 2014, was operational from September 2014 and is due for review in August 2017.	Fully Met

7	Section 4.3(m)	It is recommended that the ward manager ensures that all staff complete mandatory training in accordance with the Trust policy.	1	The inspector reviewed the ward's staff training records and noted that all staff had completed up to date training in: basic life support; vulnerable adult; managing actual and potential aggression (MAPA); child protection and manual handling training. The inspector noted that the staff training record reported that 14 staff had not completed up to date Control of Substances Hazards to Health (COSHH) training and nine staff were required to complete up to date training in relation to infection control. The inspector discussed the training deficits with the ward manager. The manager explained that they had addressed these deficits with staff and that the infection control training was now completed online. The manager was awaiting an update regarding the numbers of staff who had completed their online training. The inspector noted that the manager had taken appropriate steps to address training in relation to COSHH and staff requiring training had been booked to complete the next available course	Fully Met
8	Section 6.1(b)	It is recommended that the ward manager ensures that the patient forum is held on a regular basis and that records detail when meetings take place and when they are cancelled at patients' request.	1	The inspector reviewed the ward's patient forum records. During the previous three months meetings had been held on a weekly basis during October and on a monthly basis during November and December. Minutes of the meetings evidenced that patients' views were recorded and appropriate action steps had been taken to address presenting issues. Patients who met with the inspector reported no concerns regarding their ability to express their views or to report any issues they may have. It was positive to note that a patient from the ward represented the patients on the Six Mile ward at the hospitals patient forum.	Fully Met

9	Section 6.3.1(a)	It is recommended that the Trust reviews the availability of accommodation within the hospital site that might be utilised as a step down facility for voluntary patients in the Six Mile ward to assist in the appropriate processes of resettlement for individual patients	1	Senior managers who met with the inspector reported that the Trust continued to review the accommodation available across the hospital site on a regular basis. The inspector was informed that in accordance to regional and Trust strategy and patient resettlement policy, step down facilities were not provided by the hospital. Patient resettlement within their community was managed in partnership with the patient's local Trust to include the provision of community based step facilities where required.	Fully Met

Follow-up on recommendations made following the patient experience interview inspection on 7 and 8 May 2014

No.	Reference.	Recommendations	Number of times stated	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
10	7.3 (a), page 20	It is recommended that the Hospital's senior management team review the therapeutic wages initiative and inform RQIA of the outcome of their review.	1	The Business and Service Improvement manager had overseen the completion of a review of the hospital's therapeutic wages initiative and had informed RQIA of the outcome of the review. The inspector met with the manager during the inspection. The manager explained that a new policy had been introduced and all patients had been informed of the changes to the provision of therapeutic wages. The inspector was informed that therapeutic wages would eventually be discontinued and patients newly admitted to the hospital would not receive therapeutic wages.	Fully Met

Appendix 1

Follow-up on recommendations made at the finance inspection on 31 December 2013

No.	Recommendations	Number of times stated	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
11	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.	1	The inspector reviewed the ward's procedures for the management of patients' money and personal property. The Bisley drawer was managed in accordance to the Trust's policy and procedures. Access to the ward's Bisley drawer was monitored by the nurse in charge, who retained the key to the drawer, and recorded in the ward's patient property book. The book included a cash ledger for each patient and each entry to the ledger and the patient property book included the reasons for access and was signed by two members of staff.	Fully Met

Follow up on the implementation of any recommendations made following the investigation of a serious adverse incident

No.		Recommendations	Number of times stated	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
12	SAI 14 156	The MDT team recognise that it is important to have a multiagency meeting when a patient absconds and is away for more than two days– this would ensure that all relevant information is available to all parties and further actions/agreements can be planned on this basis. While this is the agreed timescale the MDT also agree that Multiagency meetings should take place at a time which reflects the level of risk posed to or by the individual who has absconded.	1	The inspector was informed that a multi-agency meeting is convened if a patient absconds from the ward and they are absent for more than two days. During the inspection the ward manager and members of the multi-disciplinary team relayed that if a patient absconds Police are contacted the same day and a multi-agency meeting will be convened as soon as possible.	Fully Met
13	SAI 14 156	There was no note made in Patient A's medical records of events on the 17th October, however his Consultant	1	The inspector met with each member of the ward's multi-disciplinary team including the consultant psychiatrist and	Fully Met

		has advised that this was most likely due to the lateness of the event having taken place – this has since been rectified, however MDT reminded that records should be completed as soon as practically possible when an event/incident occurs.		the ward doctor. All staff reported that they recognised the need to update patient care records as soon as possible after an incident or in circumstances when a patient has absconded from the ward. Staff informed the inspector that the transfer of patient carer documentation onto the Trust's PARIS electronic patient information system had helped to ensure that patient care records would be kept up to date. This was supported by staff being able to access the system from outside the ward.	

Quality Improvement Plan

Unannounced Inspection

Six Mile Ward, Muckamore Abbey

14 and 15 January 2015

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

The specific actions set out in the Quality Improvement Plan were discussed with the ward manager, the resource nurse, medical staff, service and operations managers, nursing staff, the senior social worker, the occupational therapist and the deputy day care manager 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	Section 5.3.3(a)	It is recommended that the ward manager ensures that patients sign their care plan. Should a patient be unable to sign this should be recorded.	1	Immediate and ongoing	The ward manager has ensured that since the inspection, all care plans have been signed by patients. If a patient was unable to sign, a record has been made to reflect this.
2	Section 5.3.1.(a)	It is recommended that the Trust reviews the ward's procedure in relation to the implementation of the ulcer risk assessment (braden scale) and the Malnutrition Universal Screening Tool (MUST).	1	31 march 2015	Since the RQIA inspection, the ulcer risk assessment (Braden) and the Malnutrition Universal Screening Tool (MUST) have been reviewed as indicated on the individual risk assessments depending on the patients needs. For the purpose of the Braden risk assessment, patients currently in Muckamorre Abbey Hospital fall into the community category.
3	Section 5.3.1(f)	It is recommended that the Trust ensures that the garden areas on the ward are appropriately maintained.	1	Immediate and ongoing	There is an ongoing maintenance programme for all garden areas within the hospital. Work is currently ongoing in the garden areas in Sixmile.

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	Dessie McAuley
NAME OF CHIEF EXECUTIVE / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Martin Dillon

Inspector assessment of returned QIP		**Yes**	**No**	**Inspector**	**Date**
A.	Quality Improvement Plan response assessed by inspector as acceptable	x		Alan Guthrie	27 February 2015
B.	Further information requested from provider				