RQIA

Mental Health and Learning Disability

Unannounced Inspection

Gillis Memory Centre, St. Lukes Hospital

Southern Health and Social Care Trust

6 and 7 January 2015

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1.0 General Information

Ward Name	Gillis Memory Centre
Trust	Southern Health and Social Care Trust
Hospital Address	St. Lukes Hospital Loughall Road BT61 7NQ
Ward Telephone number	028 37412183
Ward Manager	Sally Kennedy
Email address	sally.kennedy@southerntrust.hscni.net
Person in charge on day of inspection	Sally Kennedy
Category of Care	Mental Health- Patients over 65 with Dementia
Date of last inspection and inspection type	29/1/14 Unannounced Inspection 21/3/14 Unannounced inspection 31/7/14 Patient Experience Interview
Name of inspector(s)	Audrey McLellan

2.0 Ward profile

Gillis Memory Centre is a 24 bedded mixed gender assessment and treatment ward on St Luke's hospital site for patients with dementia. The purpose of the ward is to provide assessment and treatment to patients over 65 years of age with memory problems who need to be assessed in an inpatient care environment.

On the days of the inspection there were 19 patients on the ward. There were no patients detained under the Mental Health (Northern Ireland) Order 1986. There were three patients on the ward whose discharge from hospital was delayed

Patients within Gillis Memory Centre receive input from a multi-disciplinary team which includes three consultant psychiatrists, nursing staff, an occupational therapist, an occupational therapy assistant, physiotherapy and pharmacy. A patient advocacy service is also available.

The ward environment had been updated to help promote independence for patients with memory loss. Patients were encouraged to bring personalised items onto the ward and each patient had a memory box above their bed. The ward had three spacious communal areas which were all accessible to patients on the ward. On the days of the inspection the inspector observed patients moving freely throughout the ward. The sunroom led out to a spacious garden which was well maintained with flowers, raised bedding and seated areas. The door to the garden was left open and patients were observed going in and out of the garden independently. Information leaflets were available to patients and their families, which included information on the independent advocacy service and how to make a complaint.

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 Gillis was undertaken on 6 and 7 January 2015.

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

The recommendations made following the last unannounced inspection on 29 January 2014 and 21 March 2014 were evaluated. The inspector was pleased to note that seven recommendations had been fully met and compliance had been achieved in the following areas:

- Actions listed in the ligature point risk assessment had been fully implemented
- Staff had attended training in the appropriate recording of the use of restraint and restrictive practices
- The ward environment had been updated in keeping with best practice in dementia design guidance
- The ward had the provision of regular and structured pharmacist input
- Staff promoted and maintained the privacy and dignity of patients
- The multi-disciplinary team adhered to policies in relation to administrating medication covertly
- The ward had sufficient supply of appropriate specialised equipment to meet patients individual needs

However, despite assurances from the Trust, one recommendation had been partially met. This recommendation will be restated for a third time, in the Quality Improvement Plan (QIP) accompanying this report.

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

The recommendations made following the patient experience interview inspection on 31 July 2014 were evaluated. The inspector was pleased to note that three recommendations had been fully met and compliance had been achieved in the following areas:

- A pre-admission booklet for patients and their representatives was available.
- Work had been completed to level the floor area at the external door leading out to the garden
- Appropriate staffing levels were maintained on the ward

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

The recommendation made following the finance inspection on 6 January 2014 was evaluated. The inspector was pleased to note that this recommendation had been fully met and compliance had been achieved in the following area:

- The ward manager maintains a record of all staff who obtain the key to the safe where patient's money is stored and the reason for access.

Details of the above findings are included in Appendix 1.

5.0 Inspection Summary

Since the last inspection the inspector found progress had been made in relation to the availability of therapeutic and recreational activities on the ward. The ward had the provision of regular and structured pharmacist input whereby medication can been reviewed on a regular basis. Staffing levels had increased on the ward as the ward had recruited ten new staff members. The ward environment had been updated in keeping with best practice in dementia design guidance. There had been 18 members of staff on the ward who had completed the 'Best Practice in Dementia Care' course which was delivered by Stirling University and plans were in place for all staff to undertake this training in the future.

The following is a summary of the inspection findings in relation to the Human Rights indicator of Autonomy and represents the position on the ward on the days of the inspection.

There was evidence in the four sets of care documentation reviewed by the inspector that patients' capacity to consent to care and treatment and patients' capacity to manage their financial affairs was monitored and re-evaluated throughout the patients' admission to hospital. This was recorded in the patient's multi-disciplinary 'weekly ward team meeting' template and in the patient's person-centred nursing assessment. However in the four sets of care documentation reviewed by the inspector there were sporadic recordings of the patients' capacity each week in the weekly ward round template. A recommendation has been made in relation to this.

There was evidence in the four sets of care documentation that staff had worked in partnership with patients and had updated patients and their relatives on the outcome of weekly ward round meetings. However this was not always indicated in the care documentation at every weekly ward round. The inspector was informed by two consultants on the ward that each consultant meets with their patients after the ward round each week to update the patient and their relatives on the outcome of the ward round meeting. However these informal meetings were not always recorded in the care documentation. A recommendation has been made in relation to this.

Out of the four questionnaires returned from relatives prior to the inspection all four indicated that they had been given the opportunity to be involved in decisions regarding their relatives care and treatment. Two out of the four questionnaires stated that their relative had also been offered the opportunity to be involved in decisions in relation to their care and treatment.

The inspector spoke to four staff members on the ward in relation to how consent is gained on a daily basis on the ward. Staff demonstrated their knowledge of capacity to consent and informed the inspector of the steps they took to gain the patients consent for them to provide various forms of care and treatment

However, in one out of the four sets of care documentation reviewed by the inspector the progress notes detailed that the patient was resistant on occasions to staff attending to their personal care needs. However there was no care plan in place in relation to how staff should manage this situation. A recommendation has been made in relation to this.

Therapeutic activities are set up by the occupational therapy assistant and the staff on the ward also complete ward based activities. Staff spoke about how they would encourage patients to take part in these activities however patients are able to stop and leave the activity at any time which they frequently do.

15 out of the 19 staff members who completed and returned their questionnaires prior to the inspection indicated that they had received training in relation to human rights and 11 out of the 19 staff members indicated they had received training in relation to capacity and consent. The ward manager informed the inspector that plans are in place to ensure all staff on the ward attend capacity to consent and human rights training.

The inspector reviewed care documentation relating to four patients on the ward. There was evidenced in all fours sets of care documentation reviewed that holistic needs assessments had been completed and care plans had been devised from these assessments. Care plans had been reviewed weekly after each ward. However out of the four sets of care documentation reviewed by the inspector all four person-centred nursing assessments had not been completed fully. A recommendation has been made in relation to this.

Patients also had a ‘personal information profile’ completed in all four sets of care documentation reviewed by the inspector. This assessment detailed the patient’s likes and dislikes and was completed with the patient and their closest relation /carer. It contained information which assisted the occupational therapist to set up activities for the patient to do whilst on the ward which they enjoyed taking part in.

Part of the person centred nursing assessment included a Malnutrition Universal Screening Tool (MUST) which must be complete for all patients within 24 hours of admission. In all four assessments reviewed by the

inspector this had been completed and reviewed. In one of the four sets of care documentation the assessment indicated that the patient was at high risk and a red action plan was completed and appropriate referrals had been made. However there was no nutritional and hydration care plan completed for this patient who had been assessed as high risk. This patient had been assessed by the speech and language therapist who had made recommendations to follow in relation to food consistency and extra supplements but this information had not been recorded in a care plan to direct nursing staff. The ward manager assured the inspector that these guidelines had been followed and there was evidence of this as the patient had a fluid balance chart in place and progress notes evidenced records of the patient's progress at mealtimes. On the day of the inspection the named nurse for this patient completed a care plan for this patient in relation to their nutritional and hydration needs. A recommendation has been made in relation to this

In one of the four sets of care documentation reviewed by the inspector the dates the care plans had been reviewed was incorrect. The wrong year was recorded and the wrong month. A recommendation has been made in relation to this

In one out of the four sets of care documentation the progress notes indicated that the physiotherapist had completed an assessment and the recommendation was that the patient now required the assistance of two members of staff instead of one. It was good to note that this was followed up by the care plan being reviewed and updated on the same day. However a further assessment had been completed of this same patient and the recommendation was that the patient now needed a hoist however; the care plan on this occasion was not updated to reflect this change. A recommendation has been made in relation to this

In one set of care documentation reviewed by the inspector the progress notes indicated that a member of staff had gained information from a patient's relative with regard to fluid restrictions the patients was on due to their heart condition. It was noted in the progress notes that a fluid balance chart should be commenced and this was in place however a care plan was not in place to direct the care on the ward. A recommendation has been made in relation to this

It was good to note that in all four sets of care documentation reviewed by the inspector the patients care plans were individualised and person centred. Two out of the four sets of care plans reviewed by the inspector had been signed by the patients' relatives indicating they had been in agreement to the care and treatment planned for the patient. Progress notes also indicated that the patients' relatives/carers in all four sets of care documentation had been involved in the patients care and treatment.

It was good to note that all four sets of care documentation had a risk screening tool completed and this was reviewed at the weekly ward round. However in all four sets of care documentation reviewed by the inspector the

screening tool had been completed by the consultant and no other professional on the ward and there was no consultation with family/carers. This is not the line with the Promoting Quality Care –Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services (May 2010). In one out of the four sets of care documentation reviewed by the inspection there was a section in the risk screening tool in relation to the patients 'history of violence and aggression'. The risk screening tool indicated that there was no history of violence however in the nursing assessment which was completed on admission it stated under the section 'mental health & forensic history' that the patient had 'attempted to strangle staff in the nursing home'. The outcome of the assessments in all four sets of care documentation was also not recorded to indicate what further action was necessary. A recommendation has been made in relation to this.

In all four sets of care documentation reviewed by the inspector the template for the ward meeting was inconsistently used by the staff on the ward. Some staff members were recording a detailed account of the ward round meeting in the patients progress notes and other staff members were recording the information in the weekly ward round template. A recommendation has been made in relation to this

The ward round template was not completed in full in all four sets of care documentation. Several sections had been left blank such as who was in attendance, what the outcome of the meeting was, medical, nursing occupational therapy and social work input was not recorded under each section and family/patient views were inconsistently recorded. This template was also inconsistently signed by members of staff and family members/patients. In a number of records staff members Christian name had been recorded under the attendance and not their full name. A recommendation has been made in relation to this.

The inspector spoke to the occupational therapist on the ward who advised that they work fulltime on the ward and are assisted by an occupational therapy assistant. The occupation therapist on the ward completes post-admission assessments and pre-discharge assessments for all the patients on the ward. They also complete other assessments when patients' needs change on the ward and when directed by the multi-disciplinary team. The occupational therapist supervises the occupational therapist assistant and meets with them each day to discuss and plan activities on the ward.

All patients have a personal profile assessment completed which is used to set up activities on the ward for the patients to participate in each week. In all four sets of care documentation reviewed by the inspector these assessments had been completed. However patients did not have an individualised therapeutic and recreational activity care plan in place on the days of the inspection. A recommendation has been made in relation to this.

The activities that are offered on the ward include movement to music, reminiscing, art and crafts, a get up and go group, personal care activities and baking. Other activities organised include a newspaper reading session,

gardening in the summer months, men-only groups, ball therapy, DVD/country music evenings, fly tie fishing, bowls, singing, hand and foot massage sessions and doll therapy. Arrangements have been made for outside providers to do activities on the ward and these include: Artscare once a month, music and guitar sessions once a week and SONAS sessions once a week. The sessions completed each day include group sessions and individual sessions with the occupational therapist. In the group sessions the occupation therapy assistant is supported by a member of the nursing staff on the ward. The nurses on the ward also complete activities on the ward in the evening and weekends and throughout the day. On the day of the inspection the inspector observed activities taking place in the group activity room and also in the main ward. There was evidence in the daily progress notes of ongoing monitoring of patients participation in and outcomes of ward based activities.

Information was available on the ward in relation to the Human Rights Act (1998), the detention process, the Mental Health Review Tribunal, how to make a complaint and how to access the advocacy service. However this information was not available in easy read format. A recommendation has been made in relation to this.

An independent advocacy service provided by the Northern Ireland Association for Mental Health (NIAMH) was available on the ward each week on Monday and Wednesday. They also hold a monthly meeting on the ward which patients and their relatives can attend. If any concerns or issues are raised by patients this is brought to the attention of the ward manager to deal with. The advocate also attends the wards sub group meetings every two months to discuss ways to modernise the ward.

There is a pre-admission information booklet available for patients and their relative to read prior to their admission onto the ward and the ward also has an admission booklet for patients and their relatives when they arrive onto the ward.

The ward has questionnaires available for patients and relatives to complete which encourages them to give their opinion and view of the ward.

The inspector completed a direct observation of the ward and it was good to note that over the two days of the inspection they observed patients moving freely throughout the ward and the garden area. There was clear signage throughout the ward to assist patients with finding their way around the different areas within the ward.

The inspector spoke to one patient who stated that there were able to go out with their family when they called and over Christmas time they had spent days off the ward with their family and friends.

The inspector spoke to one relative who advised that they could take their relative out of the ward whenever they wanted they “just had to clear it with the staff”. This same relative talked about how the staff are very helpful on

the ward and have accommodated there visits onto the ward as they are very relaxed about visitors calling onto the ward. They stated that they were able to bring in various different types of snacks for their relative to eat in between meals times and they advised that it was nice being able to sit down with their relative to enjoy a snack together like they would do when at home.

The inspector reviewed four sets of care documentation on the ward and all four sets contained care plans that were individualised and person centred. However in three out of the four sets of care plans reviewed by the inspector in relation to restrictive practices the rationale for the restriction was unclear and therefore did not support the level of restriction on the ward. A recommendation has been made in relation to this.

Patients' Article 3 rights to be free from torture, inhuman or degrading treatment or punishment, Article 5 rights to liberty and security of person, Article 8 rights to respect for private and family life and Article 14 right to be free from discrimination was referenced through the four sets of care documentation reviewed by the inspector. This was also evidenced when the inspector completed direct observations of the ward and by speaking to patients and relatives on the ward.

The four questionnaires that were returned by relatives prior to the inspection indicated that relatives were aware of the restrictions in place for their relative in relation to the locked door on the ward. The progress notes for all four patients indicated that there were fully informed in relation to the patients care and treatment they were receiving on the ward and therefore they were aware of the locked door on the ward. The multi-disciplinary template was shared with patients and their relatives after each meeting and there was a section for reviewing risks in relation to the locked door on the ward and other restrictions that may be implemented. However as stated previously this template was inconsistently completed each week on the ward and a recommendation will be made in relation to this.

The inspector reviewed four sets of care documentation and there was evidence that discharge arrangements were discussed at the multi-disciplinary ward round and patients and their relatives are informed of the progress in relation to discharge arrangements. In one of the four sets of care documentation reviewed by the inspector there was evidence that a meeting had been held with patients and their relatives in relation to discharge plans. The outcome of this meeting was recorded with the action plan that needed to be in place and who was responsible for completing each action.

The inspector spoke to one relative who advised that they had been kept informed the whole way through their relative's admission on the ward and had been advised of possible discharge dates. Now that their relative was ready for discharge a meeting had been planned for them to attend. This was the second meeting as the actions from the previous meetings were to set up a care package in the community and to complete physiotherapy and occupational therapy assessments prior to discharge. A date had now been arranged for the patient to be discharged and this next meeting had been set

up to finalise arrangements. This relative informed the inspector that they were very happy with how they had been kept informed.

The ward manager advised that patients who are ready for discharge have medical and nursing assessment completed along with a pre-discharge occupation therapy and physiotherapy assessments completed. If patients are transferring to a nursing home this is usually arranged by the patient's relative/carer and when they have agreed on suitable placement, information is forwarded to the keyworker in the community. Prior to discharge the staff from the nursing home will come to the ward to gather information from the patients notes and they will also speak to the staff on the ward, the patient and their relatives/carer.

At present a nominated professional from the community attends the ward round so that information can be cascaded to the relevant keyworker for each patient on the ward who has this support in place. However when discussing discharge arrangements with a consultant on the ward they informed the inspector that this did not work as well as before when there was a designated person attached to the ward who worked in the community to liaise with the keyworker for each patient to gather important information to be brought to the ward round. The consultant stated that this assisted the professionals on the ward in making decisions regarding care and treatment on the ward and in relation to discharge. The ward manager advised that discussions have taken place with senior managers in relation to recruiting three Dementia Liaison Nurses for each area in the community that Gillis ward provides care for. This includes Armagh/Dungannon, Newry/Mourne, Craigavon/Banbridge. The plan is that the three Dementia Liaison Nurses will provide a link from the hospital to the community teams.

Details of the above findings are included in Appendix 2.

On this occasion Gillis Memory Centre has achieved an overall compliance level of substantially compliant in relation to the Human Rights inspection theme of "Autonomy".

6.0 Consultation processes

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

Patients	**3**
Ward Staff	**3**
Relatives	**1**
Other Ward Professionals	**3**
Advocates	**0**

Patients

The inspector spoke to three patients on the ward. Two out of the three patients stated they knew why they were in hospital and knew what they could and could not do on the ward. One patient appeared disorientated and was unable to answer some of the questions. However they were able to inform the inspector that they liked the ward and that the food was “very good”.

The two patients that were able to answer all the questions asked by the inspector stated that they had been involved in their care and treatment. One of the patients informed the inspector that when their medication had been changed the reason for this had been explained to them by their consultant. The other patient stated that they were going to a discharge meeting next week to discuss arrangements for when they leave the hospital. One patient stated that “this place is brilliant” and the other patient stated that the ward had “nice pleasant people”, “the consultant is a gentleman”, and “he knows his stuff”. When the patients were asked about their overall care on the ward they stated they had “no complaints to make” and “I can’t speak highly enough of the staff”.

Relatives/Carers

The inspector spoke to one relative on the days of the inspection. This relative stated that they were very pleased with the overall care and treatment their family member was receiving on the ward. They stated that they didn’t know what they would have done if their family member had not been transferred onto Gillis ward. They stated that their relative had been in another hospital and since transferring to Gillis ward there has been a marked improvement in their relatives’ condition. The relative stated that their family member’s medication had been changed which resulted in a marked improvement in their overall condition as they were now more alert and less confused. They advised that the care on the ward was “fantastic” and that the “the nurses couldn’t do enough for you”. They advised they were updated regularly on their relatives care and treatment and had attended multi-disciplinary care conferences on behalf of their relative and discharge

planning meetings. They informed the inspector that the staff had been very flexible with regard to when they visit their relative on the ward and they advised that this was a great relief as they couldn't visit at the set times. They talked about how approachable the staff were on the ward and how they were able to bring snacks onto the ward to eat with their relative "just like we do at home".

Ward Staff

The inspector met with two nurses on the ward. Both staff stated they felt well supported on the ward by the ward manager and stated that they enjoyed working on the ward. They informed the inspector that since the ward recruited new members of staff this has improved the care on the ward. They stated that the patients are now provided with more continuity in their care with having core staff on the ward and not having to rely on bank staff. The staff stated that the new staff members have integrated well into the ward and they feel that staff morale has improved.

The staff advised that the ward works very closely with patients' family members/carers and that this helps to ensure that individualised care plans are developed for patients on the ward which includes their likes and dislikes. The staff informed the inspector that the ward continually reviews any restrictive practices. They advised that they work at all times to ensure they gain patients consent to care and treatment and if patients refuse they would respect this and try to encourage them at a later stage in the day. One staff member informed the inspector that "as long as they are safe and not coming to any harm" they would not intervene. All staff were able to identify various different techniques they use on the ward to assist patients in attending to their activities of daily living when they appear confused and disoriented.

Other Ward Professionals

The inspector met with two of the consultant psychiatrists for the ward. The consultants informed the inspector that the patients' capacity to consent to care and treatment is reviewed on an ongoing basis. However both consultants agreed that the template used for the weekly ward round meeting had been inconsistently completed each week. They both advised that after the ward round each week they meet with the patients and their family members if they are on the ward to update them on the outcome of the meeting. They also advised that these meetings are not always recorded in the patients care documentation. The two consultants advised that there are three consultants on the ward who cover the three areas that the Gillis ward provides a service to in the community. Each consultant holds a ward round each week to review patients care and treatment.

When discussing links with the community teams with one of the consultants they informed the inspector that there had previously been a designated person attached to the ward who worked in the community to liaise with the keyworker for each patient to gather important information to be brought to the ward round each week. The consultant stated that this assisted the professionals on the ward in making decisions regarding care and treatment

on the ward and in relation to discharge arrangements. The inspector discussed this with the ward manager who advised that discussions have taken place with senior managers in relation to recruiting three Dementia Liaison Nurses for each area in the community that Gillis ward provides care to; this includes Armagh/Dungannon, Newry/Mourne, and Craigavon/Banbridge. The plan is that the three Dementia Liaison Nurses will provide a link from the hospital to the community teams.

The inspector also met with the occupational therapist who works fulltime on the ward and is supported by an occupational therapy assistant. They advised that they feel that since the recruitment of the occupational therapy assistant on the ward this has assisted greatly with the therapeutic programmes provided to the patients. They advised that they themselves are heavily involved in completing post-admission and pre-discharge assessment, attending three wards rounds each week and completed other assessment when this has been agreed at the multi-disciplinary ward rounds. Therefore they were unable to provide the level of activities on the ward that patients needed. They informed the inspector that with the support of the occupational therapy assistant the ward can now hold three sessions of therapeutic/recreational activities each day with patients on the ward Monday to Friday

Advocates

There were no advocates available to meet with the inspector on the days of the unannounced inspection.

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

Questionnaires issued to	Number issued	Number returned
Ward Staff	20	16
Other Ward Professionals	5	3
Relatives/carers	19	4

Ward Staff

There were 16 questionnaires returned by ward staff in advance of the inspection. Information contained within the questionnaires indicated that eight ward staff had received training in capacity to consent and 12 had attended training on human rights. 15 stated that they were aware of the Deprivation of Liberty Safeguards (DOLS) – interim guidance and 12 staff members indicated they had received training in relation to restrictive practices. Out of the 16 questionnaires returned 11 indicated they had received training on meeting the needs of patients who need support with communication and 16 staff members indicated that patient’s communication needs were recorded in their assessment and care plan and that they were aware of alternative methods of communicating with patients. They all

indicated that these methods were used on the ward. The 16 ward staff reported that the level of therapeutic and recreational activities meets the patients individual needs on the ward.

Other Ward Professionals

There were three questionnaires returned from other ward professionals in advance of the inspection. Information contained within the questionnaires indicated that all three professionals had received training in capacity to consent and on human rights. All three were aware of the Deprivation of Liberty Safeguards (DOLS) – interim guidance. The three ward professionals indicated that they had not received training in relation to restrictive practices.

Two of the ward professionals indicated they had received training on meeting the needs of patients who need support with communication. All three ward professionals indicated that patient's communication needs were recorded in their assessment and care plan. The three ward professionals indicated that they were aware of alternative methods of communicating with patients and stated these methods were used on the ward. The professionals indicated that the level of therapeutic and recreational activities meets the patients individual needs on the ward.

Relatives/carers

Four questionnaires were returned by relatives/carers in advance of the inspection. It was good to note that all three relatives indicated that they felt the care on the ward was excellent. Relatives/carers stated that:

"Any nurses I have observed seem to have time for patients, treating people with respect and as individuals",

"My X has received the best of care since she was admitted to the Gillis ward. My brother, sister and I have nothing but utter respect and admiration for the nurses and care assistants who look after all the patients with loving care and great attention which we are very happy to see X getting; nothing is any bother to any member of staff"

"Top class care and service you will go a long way to get anything better"

All four relatives/carers stated that they had been given the opportunity to be involved in decisions in relation to their relatives care and treatment. Three of the four questionnaires returned indicated that their relative had an individual assessment completed in relation to therapeutic and recreational activities and that their relative participated in these activities on the ward. Three relatives/carers indicated that there relative had a person centred discharge plan completed and that they had been involved in this. One relative/carer stated that they had been given a date to meet with the consultant to discuss discharge arrangements.

7.0 Additional matters examined/additional concerns noted

Complaints

The inspector reviewed complaints received by the ward between 1 April 2013 and 31 March 2014. Three complaints from relatives were recorded over this period of time and had been fully resolved to the satisfaction of the complainant.

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 unannounced inspection on 29 January 2014

No.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	It is recommended that the Trust ensures that all actions listed in the ligature point risk assessment of 19 June 2012 are implemented in full.	On the day of the inspection all actions had been implemented from the assessment of 19 June 2012. One action in relation to bed curtain rails had been outstanding on the previous inspection however all bed curtain rails are now collapsible.	Fully met
2	It is recommended that the ward sister ensures that training is provided for staff in relation to the appropriate recording of the use of restraint or restrictive practices.	All staff have been trained at a local level with regard to recording the use of restraint or restrictive practice. A training plan will be set up to ensure all staff are trained in relation to deprivation of liberty and human rights. The inspector spoke to staff who all demonstrated a good understanding of restrictive practices and how this procedure is monitored and reviewed by staff on the ward and the multi-disciplinary team.	Fully met
3	It is recommended that the Trust makes improvements to the ward environment in keeping with best practice in dementia design principles, with particular reference to way-finding landmarks, orientation information, use of signage, use of colour and contrast, access to safe outside spaces, lighting and flooring.	Improvements have been made to the ward environment and there are now way-finding landmarks, orientation information, use of signage, use of colour and contrast, access to safe outside spaces, lighting and flooring.	Fully met
4	It is recommended that the Trust ensures that there is the provision of regular and structured pharmacist input	All new admissions are now referred to the Pharmacist who scrutinises the patients' medical kardex and reconciles this with the patients' medical history. They sign the medical kardex when they have completed their review. The pharmacist also attends the ward rounds and when changes are made to	Fully met

	for all patients on the ward.	medication regimes and they review the patients medication as and when requested.	
5	It is recommended that the Trust review the composition of the multidisciplinary team and availability of psychotherapeutic interventions to patients on the ward.	Patients can be referred to psychology when this has been recommended by the multi-disciplinary team. However to date psychology is not part of the multi-disciplinary team on this ward. The Assistant Director of Mental Health Services has had internal discussions with the Head of Psychology in the Trust to explore any potential Psychology resources that could be allocated to Gillis ward. The Assistant Director of Mental Health Services has also corresponded with the Commissioner for the service to highlight the deficit in relation to clinical specialities for this service. However, at the time of the inspection a psychologist was not part of the multi-disciplinary team. This recommendation will be restated for a third time	Partially met

Follow-up on recommendations made following the unannounced inspection on 21 March 2014

No.	MHLD Doc No	Reference.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	17	6.3.2. a	It is recommended the ward manager ensures that staff promote and maintain the privacy and dignity of all patients.	The inspector completed observations of the ward over the two days of the inspection and observed staff to be respectful and courteous towards patients on the ward. Staff ensured patients received privacy when carrying out personal care tasks and they were observed treating patients with dignity and respect when assisting patients at mealtimes.	Fully met
2	17	5.3.1. f	It is recommended the ward manager ensures the multi-disciplinary team adhere to the SHSCT policy in relation to the administration of medication covertly.	The inspector was advised by the ward manager that there were no patients on the ward at the time of the inspection who received their medication covertly. The inspector spoke to staff on the ward who fully understood the policies and procedures around the administration of covert medication and could describe their practice around any restrictive measures.	Fully met
3	17	5.3.1. f	It is recommended the ward manager ensures that a sufficient supply of appropriate specialised equipment is available on the ward to meet individual patient needs.	The inspector was advised that six new slings were ordered and are now available on the ward therefore there is now a sufficient supply on the ward to care for all patients on the ward.	Fully met

Appendix 1

Follow-up on recommendations made following the patient experience interview inspection on 31 July 2014

No.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	It is recommended that the ward manager ensure that the pre admission information booklet for patients and their representatives is finalised and made available.	A new pre admission information booklet was available for patients and their representatives on the ward	Fully met
2	It is recommended that the Trust ensures that work is completed to level the floor area at the external door leading to the garden.	Work had been completed to level the floor area at the external door leading to the garden.	Fully met
3	It is recommended that the Trust ensures that appropriate staffing levels are on the ward at all times to ensure the safety of patient care.	The ward had recruited 10 new staff member to be part of the core team. The inspector reviewed the staffing duty rota over a two week period and there was evidence that the ward had appropriate staffing levels over this period. There was an average of 11 staff on the ward to care for 19 patients two of whom had 1:1 support. Therefore on average there were a total of 9 staff members available to manage the care and treatment of 17 patients.	Fully met

Follow-up on recommendations made at the finance inspection on 6 January 2014

No.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	It is recommended that the ward maintains a record of all staff who obtain the key to the safe where patient's money is stored and the reason for access	The nurse in charge of the ward holds the key to the safe. There is a record of the person who has accessed the safe and this is countersigned by another staff member.	Fully met

Appendix 1

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

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

Quality Improvement Plan

Unannounced Inspection

Gillis Memory Centre, St Luke's Hospital

6 & 7 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 and the clinical service co-ordinator 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	6.3.1 (a)	It is recommended that the Trust review the composition of the multidisciplinary team and availability of psychotherapeutic interventions to patients on the ward.	3	7 May 2015	The Mutidisciplinary Team in Gillis comprising of medical, nursing and occupational therapy staff provide psychotherapeutic interventions both during 1:1 and group engagments. The Trust continues to be in negotiation with commissioners in relation to permanent funding of clinical psychology resource for Gillis and indications are hopeful that 0.5 wte Band 8a Psychologist will be funded in 2015/16. Currently if a patient requires a clinical psychology assessment this can be requested and obtained
2	5.3.1 (f)	It is recommended that the ward manager ensures that the weekly ward round template is completed in full to record the patients' capacity to consent to their care and treatment and to evidence that this is monitor and re-evaluated regularly on the ward.	1	Immediate and ongoing	The Ward Sister will meet with members of the MDT to review the format of the Weekly MDT Review Sheet by May 2015. In the interim the Ward Sister has requested all disciplines who attend the MDT meeting to ensure the patients capacity to consent to care and treatment is recorded on the weekly review sheet. The ward sister will implement a periodic audit of MD template to measure compliance with this

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
					requirement
3	5.3.1 (f)	It is recommended that the ward manager ensures all discussions/meetings with patients are recording in the patients care documentation, which include meetings held with patients after each ward round.	1	Immediate and ongoing	The Ward Sister will meet with members of the MDT to review the format of the Weekly MDT Review Sheet by May 2015 . The Ward Sister has directed all disciplines to ensure all meetings with patients are recorded in patient file, including meeting after the MDT meeting. A sample audit of care documentation will be impemetened and results retained in evidcen of compliance
4	5.3.1 (f)	It is recommended that the ward manager completes regular audits of the care documentation to ensure accurate up to date information is recorded on the care the patients are receiving on the ward in accordance with, Good Management, Good Records, (DHSSPS) December 2014 guidelines.	1	Immediate and ongoing	Monthly NIPEC audits are already completed on mandatory requirements for record keeping and this forms part of our nursing quality indicators. The Ward Sister in conjunction with Nurse Governance Offcier will identify a care plan audit suitable for implementation in this care environment by May 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
5	6.3.2 (c)	It is recommended that the ward manager ensures that information relating to the detention process, the Mental Health Review Tribunal, the complaints procedure, consent and capacity, human rights and the advocacy service is made available on the ward in a format suitable to patients individual needs so that they are able to understand the implication of their care and treatment	1	7 May 2015	We are in the process of developing easy read versions for patients / carers on Human rights Detention process & Mental Health Review Tribunal The Complaints procedure Advocacy Service
6	5.3.1 (f)	It is recommended that the ward manager ensures that all person centred nursing assessments are completed in full	1	Immediate and ongoing	The Ward Sister has put in place a communication aid to ensure follow up and timely completion of all nursing assessments and documentation.
7	5.3.1 (a)	It is recommended that the ward manager ensures patients assessed needs are indicated in a care plan to direct staff on the ward and when patients are reassessed by other professionals on the ward with further recommendations that a	1	Immediate and ongoing	As per response to recommendation 4. The Ward Sister has advised staff on the need for the timely updating of care plans to reflect reassessment of patients by other professionals and their recommendations in relation to the patients care and treatment .

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
		care plan is developed to reflect the care and treatment for the patient			
8	5.3.1 (a)	It is recommended that the ward manager ensures that all information received pertaining to the care and treatment of the patients on the ward is reflected in the patients care plans and this includes updated information received from patient's relatives and carers to ensure patients are proved with the appropriate care on the ward.	1	Immediate and ongoing	The Care palnning audit will measure compliance with this recommendation. Currently all relatives are asked to complete the "This is me!" booklet so that the ward team can obtain detailed information about the individual to assist them in developing personalised care plans.
9	5.3.1 (a)	It is recommended that the ward manager ensures that all risk assessments are completed in accordance with the Promoting Quality Care –Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services (May 2010).	1	28 February 2015	The Ward Sister has communicated to all nursing staff the requirement for the Dementia risk screening tool to be completed and signed by both the admitting Doctor and Nurse

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
10	5.3.1 (f)	It is recommended that the ward manager ensures that all staff record a detailed account of the multi- disciplinary ward round meetings in the ward round template . Each section of this template should be completed in full to include who was in attendance, what the outcome of the meeting was, medical, nursing, occupational therapy and social work input and family/patients views. This template should be signed by all members of staff and family members/patients who were at the meeting. Signatures should be recorded with the staff members full name.	1	Immediate and ongoing	The Ward Sister has directed all Staff Nurses attending the ward round to ensure that all sections of the weekly review sheet are completed fully by all disciplines responsible for each section.
11	5.3.1 (a)	It is recommended that the ward manager ensures patients have an individualised therapeutic and recreational activity care plan in place which has been developed from their 'personal profile	1	31 March 2015	O.T and nursing staff will jointly develop a therapeutic and recreational activity care plan for each patient which is reflective of their 'person centred nursing assessment' and 'This is Me' booklet.

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
		assessment' and their 'person centred nursing assessment.			
12	5.3.1 (a)	It is recommended that the ward manager ensures that care plans in relation to perceived or actual deprivation of liberty include an outline of the individual risk to that patient and a rationale to support the level of restriction in terms of proportionality and necessity	1	28 February 2015	The Ward Sister has arranged training sessions for all staff and in particular to support band 5 staff in developing their record keeping skills specifically in relation to recording patients individual risks , safeguards against any perceived or actual deprivation of liberty and rationale to support the level of restriction in terms of necessity and proportionality

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	Sally Kennedy
NAME OF CHIEF EXECUTIVE / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Miceal Crilly on behalf of Mairead McAlinden

Inspector assessment of returned QIP				**Inspector**	**Date**
		Yes	**No**		
A.	Quality Improvement Plan response assessed by inspector as acceptable	x		Audrey McLellan	**2/3/15**
B.	Further information requested from provider				