The Regulation and Quality Improvement Authority

RQIA

Mental Health and Learning Disability

Unannounced Inspection

Rosebrook PICU, Craigavon Area Hospital

Southern Health and Social Care Trust

12 & 13 February 2015

npm national preventive mechanism

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Contents

1.0 General Information

Ward Name	Rosebrook PICU
Trust	Southern Health and Social Care Trust
Hospital Address	Craigavon Area Hospital 68 Lurgan Road Portadown BT63 5QQ
Ward Telephone number	028 3752 2381 / 028 3741 2299
Ward Manager	Wendy Kelly
Email address	WendyK.kelly@southerntrust.hscni.net
Person in charge on day of inspection	Wendy Kelly
Category of Care	Psychiatric intensive care unit (PICU) for adult mental health patients.
Date of last inspection and inspection type	29 July 2013
Name of inspectors	Audrey McLellan Brian Fleming

2.0 Ward profile

Rosebrook is a psychiatric intensive care unit (PICU) for adult mental health patients. The ward provides a low secure, mixed gender environment for patients in the Southern Trust catchment area. This service was relocated in June 2014 from ward 3, St Luke's Hospital site, Armagh to its current location**.**

The ward is supported by a multi-disciplinary team that includes a consultant psychiatrist, nursing staff, an occupational therapist, a social worker and a pharmacist.

On the days of the inspection there were ten patients in the ward and nine patients were detained in accordance with the Mental Health (Northern Ireland) Order 1986. There was one patient whose discharge was delayed and there were no patients on leave.

The ward was bright, clean and clutter free. The inspectors found the atmosphere to be relaxed and calm. Patients had their own bedroom with en suite facilities. There was a training kitchen on the ward, a large lounge area and two smaller quiet rooms. The ward also had access to a pool table, table

tennis and an exercise bicycle in a courtyard area which led off from the main communal area. Patients were observed moving freely throughout the ward. Patients could access a large well maintained garden.

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

4.0 Review of action plans/progress

An unannounced inspection of Rosebrook PICU was undertaken on 12 and 13 February 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 July 2013 were evaluated. The inspector was pleased to note that seven recommendations had been fully met and compliance had been achieved in the following areas:

- There was an occupational therapist working on the ward four days a week
- The ward had an outdoor area for patients to smoke and patients had access to this area throughout the day.
- The Trust had recently completed a review of the staffing levels on all wards across the bluestone site and were in the process of recruiting staff.
- Patients were involved in individual and group therapeutic activities.
- Team meetings were held regularly on the ward. These detailed issues raised, actions taken and outcomes.
- The complaints policy had been reviewed and updated

However, despite assurances from the Trust, one recommendation had been partially met and three recommendations had not been met. Two recommendations will require to be restated for a second time and one 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 recommendation made following the patient experience interview inspection on 28 July 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:

- Patients' rights had been explained to them with regard to the detention process and information was available to patients on the ward which explained this process.

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 the

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

- A record was kept of the reason why the safe had been opened and this was signed by two members of staff. The nurse in charge holds the safe key

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

Two serious adverse incidents occurred on this ward on 3 and 5 June 2014. Seven recommendations made by the review team who investigated the incidents were evaluated during this inspection. It was good to note that compliance had been achieved in relation to:

- The Trust has implemented the Regional Search Guidelines (February 2014) with associated training and have issued search wands to the relevant areas.
- The search policy to support the Regional Search Guidelines is currently out for consultation and should be in place by April 2015. The Trust will ensure that this is implemented on the ward.
- All staff working within the ward wear a personal attack alarm
- The Trust has reviewed its processes for the allocation / collection of personal attack alarms within mental health inpatient wards.
- All patients are assessed on admission to the ward by two members of staff, the nurse on duty and a doctor.
- The Trust has written to the HSCB regarding regional guidance in relation to the removal of violent and unwell persons from HSC facilities into PSNI custody and the role/authority of the Forensic Medical Officer (FMO) in such circumstances
- The Trust have written to the PSNI regarding the importance of thorough search processes

Details of the above findings are included in Appendix 1.

5.0 Inspection Summary

Since the last inspection the ward has relocated from ward 3, St Luke's Hospital site, Armagh to Rosebrook on the Craigavon Area Hospital site. An occupation therapist was working fulltime on the ward and therapeutic activities had been set up. Patients had direct access out to a garden area which they did not have in the previous ward.

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 all three sets of care documentation of regular clinical review by both the junior medical staff and the consultant on the ward. This

was evident in the patients' progress notes and in the multi-disciplinary team record. There was also evidence of pharmacist input in relation to reviewing patients' medication.

There was evidence in the three sets of care documentation reviewed by inspectors that patients' mental health status and capacity to consent to care and treatment was monitored and re-evaluated throughout the patients' time on the ward. This was evidenced in the patients' progress notes by the nursing and medical staff and by the occupational therapist and social worker. It was good to note that care records indicated patients had been asked to complete various activities and when they had refused this decision was respected. There was evidence of staff encouraging patients to complete tasks at a later time in the day and patients agreeing to do so.

In one of the three sets of care documentation reviewed the inspectors found that staff had raised concerns regarding a patients' capacity to consent to a placement in the community. Discharge planning meetings had been held with the community team to plan the patients' future accommodation arrangements. However there was no care plan in place detailing the outcome of a capacity assessment in respect of this patient. There was no reference made on how decisions would be made regarding their future accommodation and how this was going to be managed. A recommendation has been made.

The inspector spoke to three staff nurses on the ward who demonstrated a good level of understanding of how to gain consent from patients prior to patients receiving care and treatment, and what they would do if patients refused treatment.

There were nine questionnaires returned from staff prior to the inspection and six of the nine staff indicated that they had received training in human rights and capacity to consent.

Inspectors found that patients' capacity was discussed at the multi-disciplinary team meetings. However the manner of recording was very unclear and did not indicate what specific area of capacity was assessed. A recommendation has been made.

The three sets of care documentation evidenced that patients had been involved in their care and treatment. Patients were seen by the consultant regularly. Patients also attended their multi-disciplinary team meetings. However, the multi-disciplinary team (MDT) meeting template was inconsistently completed and therefore did not always indicate if patients had attended the meeting, and if not, the reasons why not. There were also a number of MDT records which did not indicate the outcomes/actions that had been agreed at the meetings. A recommendation has been made.

Inspectors reviewed three sets of care documentation in relation to patients who had transferred from an acute mental health ward on the hospital site.

The deputy ward manager advised that patient's assessments had been completed in the transferring wards. However, assessments were not available in two out of the three sets of care documentation. When this was discussed with the deputy ward manager they located one of the assessments in a previous set of notes. There was no evidence that these assessments had been reviewed. Referral forms had been completed when patients transferred to the ward. However, these referrals did not include an up to date holistic assessment of the patient's needs. A recommendation has been made in relation to this.

Inspectors were concerned to note that in three sets of care documentation reviewed patients' care plans had not been completed following assessment of the patients' needs. In one set of care documentation there were no current care plans in place. This patient's assessment indicated that they required further care and treatment in a medium secure unit. The patient's previous care plans had been discontinued. The inspectors were concerned that the patient had no care plans in place to direct the care they should receive on the ward. When this was discussed with the ward manager, the manager was unable to give a reason why care plans were not in place.

In another two sets of care documentation, the assessed need of the patients were not detailed in care plans to reflect the care and treatment these patients required. A recommendation has been made in relation to this.

One patient's records detailed that the patient had aphasia. However there was no care plan in place to indicate how this patient's aphasia was going to be managed on the ward. There was no evidence of assessments completed or referrals made to the speech and language therapist or if alternative methods of communication had been considered for this patient. A recommendation has been made.

The inspectors reviewed care plans that were in place in two sets of care documentation and there was no record of patients having signed their care plans or an indication of the reasons why. This recommendation will be restated for a third time.

Inspectors were concerned to note that in the care documentation reviewed, patients' care plans had not been reviewed appropriately. A recommendation has been made

Inspectors noted that patients were seen by the occupational therapist and there were individual and group activities available for patients. However, inspectors were concerned to note that therapeutic activities were not taking place when the occupational therapist was not on the ward. A recommendation has been made

Of the three sets of care documentation reviewed by the inspector, there was one occupational therapy assessment completed. When this was discussed

with the ward manager they did not know why OT assessments had not been completed. A recommendation has been made in relation to this.

There were was no individual activity plans in place for patients set up from assessments completed by the occupational therapist. A recommendation has been made in relation to this.

There was no evidence throughout the care documentation that patients' Article 8 human rights, right to respect for private and family life, had been considered. The inspectors met with one relative who advised that that visiting times on the ward were restricted as there was only one room available and it had to be booked each time. Therefore if another family had booked the room they were unable to visit their relative. The ward had relaxed the visiting times as relatives could visit each day from 2pm to 8 pm on Saturday and Sunday and 3 pm to 8 pm on Monday –Friday. However with only one room available this restricts the time family members can visit their relatives. A recommendation has been made in relation to this.

This relative also raised concerns regarding the lack of information received in relation to their relatives care and treatment. This was discussed with a nurse on the ward who explained that relatives can speak at any time to nursing staff to gain an update on their relative's condition and the activities they are taking part in. They advised that as it is a locked ward and staff have to open the door to let patients' relatives in and out of the ward this is a good opportunity to discuss the patients' care and treatment. The nurse advised that they are in the process of devising a leaflet to give to relatives after each multi-disciplinary meeting which will detail information regarding the patients care and treatment. They have consulted with the multi-disciplinary team with regard to this and a number of relatives who have all advised that they feel this would be a good way to keep them updated.

The inspector spoke to a nurse on the ward regarding therapeutic activities and it was good to note that staff recognised that improvements could be made in relation to the therapeutic activities on the ward. A plan was in place to implement a 'Continuous Observation Individualised Therapeutic Care Plan'.

There was evidence in the progress notes in the three sets of care documentation reviewed that the occupational therapist had continually encouraged patients to attend to activities on the ward. There was evidence of a separate record of activities completed by patients. However this was not recorded in each patient's care documentation. A recommendation has been made in relation to this.

There was no evidence in the care documentation reviewed by the inspector of patients taking part in activities in the evenings and at the weekends. On the days of the inspection the occupation therapist was on annual leave and the inspector did not see any activities taking place during this time. A recommendation has been made in relation to this.

Information regarding the detention process, the mental health review tribunal, making a complaint and the independent advocacy service was available in the activity room. However, there were patients on the ward who did not use the activity room, therefore did not have access to this information. The room was closed when the occupation therapist was not on the ward. A recommendation has been made.

The inspector reviewed two sets of care records of patients who had been detained in accordance with the Mental Health (Northern Ireland) Order 1986. There was evidence in only one set of care record of a care plan in place in relation to the detention process and the patient rights whilst detained. A recommendation had been made

The social worker on the ward advised inspectors that the majority of patients admitted onto the ward have transferred from one of the acute wards on the hospital site. Therefore in most cases they have already been detained and this process would have been explained to them. However they advised the inspectors that they ensure patients understand their rights in relation to the detention process as soon as the patient is medically fit to discuss this.

The ward had an information booklet which detailed patients' rights, information about the multi-disciplinary team, restricted items, storage of valuables, visiting arrangements, protected mealtimes the smoking policy, the advocacy service, how to make a complaint/compliment and contact details of RQIA.

An independent advocate visited the ward every Wednesday to speak to the patients and information in relation to the advocacy service was displayed in the activity room.

There was no reference in the care documentation that patients' human rights had been considered in relation to Article 3 rights to be free from torture, inhuman or degrading treatment or punishment, Article 5 rights to liberty and security of person and Article 14 the right to be free from discrimination. However when the inspector spoke to three members of staff on the ward in relation to the patients' rights they appeared to have a good understanding of how they would ensure they uphold patients' human rights. Staff agreed that this is not always evidenced in the care documentation. A recommendation has been made in relation to this.

The inspector reviewed records of patient meetings which should have been held on the ward each week (Sunday) as documented in the previous quality improvement plan. However, records indicated that there were no meetings held from January 2014 to September 2014. Meetings from September 2014 had been held approximately once a month. This recommendation will be restated for a second time

The inspector observed a number of ‘blanket’ restrictions on the ward including the locked doors, patients’ money kept in the ward safe, the outside court yard locked and the bedroom areas were locked at set times during the day. However, in the three sets of care documentation reviewed by the inspector assessments and care plans did not provide a clear rationale around each restriction and /or deprivation of liberty. One staff member informed the inspector that the main door of the ward was locked “because it is the policy to do so”. The ward information booklet identified items that were restricted on the ward and therefore would be removed from patient’s possessions when admitted onto the ward. However, the reason for this restriction was not detailed in the patients individual care plans and there was no record of this restriction having been discussed with patients. A recommendation has been made

The inspector observed one patient leaving the ward. When this was discussed with the staff they advised that this patient had been given access leave off the ward to go to the local shop. This had been discussed and agreed at the multi-disciplinary team. The staff on the ward advised that restrictive practices are discussed at the ward round each week and there are a number of patients on the ward who had ground access and access to the local shops. The inspector reviewed the care documentation for one of the patients who had access to the local shop. There was no care plan in place in relation to the patient’s access arrangements off the ward. It was unclear as to the rationale around this arrangement. A recommendation has been made in relation to this.

In one set of care documentation there was a care plan in relation to a restriction on a patient having access to their cigarettes. There was no evidence of an individualised care plan in place to detail the rationale for the use of this level of restriction in terms of necessity and proportionality. A recommendation has been made in relation to this.

The inspectors met with three ward staff who demonstrated an understanding of the restrictive practices in place on the ward; however, they did not understand how this should be recorded in the patients’ care documentation. Four out of the nine staff who returned questionnaires prior to the inspection indicated that they had not received training in relation to restrictive practices. A recommendation has been made in relation to this.

On the days of the inspection there were three patients on 1:1 enhanced observations and one patient was on 2:1 observations. Observation records were reviewed and the inspector noted that these were completed in accordance with the Trust policy and procedures.

The inspector reviewed the recent incidents of physical interventions on the ward. This included situations where staff had to use the ‘extra care suite’ as a form of seclusion when patients needed this level of care and support. There was evidence that this was monitored and only used when all de-escalation techniques had been exhausted. There was evidence that staff

had adhered to the Trust's policy on the management of incidents of violence and aggression. The inspector reviewed the nursing staff training records in relation to the Management of Actual or Potential Aggression (MAPA) and all staff had completed up to date training.

The ward manager stated that there was one patient on the ward whose discharge into the community had been delayed. There was evidence in the patient's care documentation that discharge planning meetings had been held with the community team. The patient had met with the ward social worker to discuss plans for their future accommodation arrangements. The social worker on the ward advised that they link in with community teams when patients are ready to be discharged into the community. Before the patient is discharged a discharge summary is completed with the ward staff. However the social worker stated that patients usually transfer back to the ward they were transferred from and are rarely discharged directly into the community.

Transfer arrangements to other wards are discussed at the weekly ward conference. Links are made with the transferring ward by the social worker or a staff member to update staff on the patients who will be transferring to them and to see if a bed is available. The patient's notes travel with the patient to other wards and a staff member accompanies the patient to the transferring ward and completes a handover on the ward. Patients are kept informed of transfer arrangement by staff on the ward. There was evidence in the care documentation reviewed by the inspector of staff liaising with wards when patients had been transferred from another ward to Rosebrook.

Details of the above findings are included in Appendix 2.

On this occasion Rosebrook has achieved an overall compliance level of moving towards compliance 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	**1**
Ward Staff	**3**
Relatives	**1**
Other Ward Professionals	**2**
Advocates	**0**

Patients

The inspectors spoke to one patient on the ward who showed them around their room and ensuite. The patient told the inspector that their bedroom was comfortable and that they were hoping to get home soon. The patient was unable to answer any other questions in relation to their care and treatment. They appeared to have limited understanding of the questions asked and seemed distracted. They did however inform the inspector that they had met with their consultant.

Relatives/Carers

The inspectors spoke to one relative who advised that they had not been involved in the patient's care and treatment. They stated they were unaware that multi-disciplinary team meetings were held each week and they stated they did not know what their relative did all day as they were unable to tell them. This was discussed with a staff nurse who advised that the information booklet about the ward is available in the main entrance hall. This details information on how family members can arrange to meet with the consultant; however this booklet was not displayed in the visitor room. A recommendation has been made in relation to this

The relative advised that there were restrictions on the ward regarding visiting times as there is only one visitors room on the ward and relatives/carers have to ring into the ward to book this room. They advised that the visiting hours are flexible however this can be restricted by having to book the room. A recommendation has been made in relation to this

The relative also raised concerns regarding the length of time they have to wait outside before a staff member lets them into the ward. The inspector also experienced difficulties getting into the ward and had to wait on two separate occasions over 10 minutes before a staff member came to the door. This was discussed with the ward manager and the patient flow and bed management coordinator at the feedback meeting. It appears that if staff are not at the nurses' station they do not hear the doorbell. A recommendation has been made in relation to this.

The relative stated that they had difficulty getting through to the ward on the telephone. When this was discussed with the ward manager they advised that the mobile phone charger had been broken but is now fixed so there should be no more problems.

Ward Staff

The inspectors met with three ward staff on the days of the inspection. They informed the inspectors that the ward holds regular multi-disciplinary team meetings and patient are invited to attend. The staff spoke about restrictive practices on the ward and how the ward continually reviews restrictions at the

ward round each week. In relation to the use of MAPA intervention and the 'extra care suite', the staff advised that these methods were used as a last resort and only after de-escalation techniques have been used without effect.

One staff nurse advised that since the ward moved to the new site in Craigavon they have built up good working relationships with other colleagues on the hospital site.

Two of the staff nurses informed the inspectors that they had recently completed a personal development course and part of this course involved implementing a service improvement on the ward. One staff nurse was in the process of introduced a new information leaflet to keep relatives/carers updated on the care and treatment their relative was receiving on the ward. The other staff nurse was in the process of introducing a 'Continuous Observation Individualised Therapeutic Care Plan' which will be implemented when staff are working with patients who are on continuous observations so that therapeutic programmes can be continued.

Other Ward Professionals

The inspectors spoke to the consultant on the ward who advised that they had responsibility for the ward and they also hold a community caseload. They are supported on the ward by a senior house officer. They informed the inspector that patients meet with them and a nurse on the ward prior to the ward round each week to discuss their care and treatment and to review their risk assessment. They advised that occupational therapy is provided on the ward and nurses follow through on the occupational therapist work. They feel that they have good working relationships with other colleagues in the acute wards.

The inspectors also spoke to the social worker who is based on the ward fulltime. They advised that they are the Bluestone hospital lead for safeguarding and part of this role involves being an investigating officer and completing achieving best evidence interviews and clarification interviews with patients. They also complete social histories for patients who are not known to other professionals in the community. They link in with the community teams in relation to arranging discharges into the community. However in this ward they advised patients usually transfer back to the ward they had transferred from and they would assist in the transfer arrangements. They have assisted patients with their application to the mental health review tribunal and given advice to patients in relation to housing arrangements and benefits

Advocates

The advocate was not available on the days of the inspection

Questionnaires were issued to staff, relatives/carers and other ward professionals in advance of the inspection. The responses from the

questionnaires were used to inform the inspection process, and are included in inspection findings.

Questionnaires issued to	Number issued	Number returned
Ward Staff	15	7
Other Ward Professionals	5	2
Relatives/carers	10	0

Ward Staff

There were seven questionnaires returned by ward staff in advance of the inspection. Information contained within the questionnaires indicated that four ward staff had received training in capacity to consent and human rights. Six staff stated that they were aware of the Deprivation of Liberty Safeguards (DOLS) – interim guidance and four indicated they had received training in relation to restrictive practices. Out of the seven questionnaires returned four staff indicated they had received training on meeting the needs of patients who need support with communication. Seven staff 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. Six staff reported that the patients have access to therapeutic and recreational activities on the ward and seven staff indicated this meets the patients' individual needs. The following comment was made by a ward staff regarding the care and service provided by the ward:

"The occupational therapist on our ward works very hard to create programmes/activities to meet the needs of the clients in the ward. The nursing staff work with the OT and patients to create a more relaxed experience for every individual"

Other Ward Professionals

Two questionnaires were returned by the social worker and the consultant in advance of the inspection. Information contained within the questionnaires indicated that both professionals had received training in capacity to consent and human rights. They were aware of the Deprivation of Liberty Safeguards (DOLS) – interim guidance and one professional had attended training in relation to restrictive practices. They both indicated they had received training on meeting the needs of patients who need support with communication and they were aware of alternative methods of communicating with patients. They indicated that these methods were used on the ward. They reported that the level of therapeutic and recreational activities meets the patients individual needs on the ward. One professional stated that on occasions patients choose not to take part in activities.

Relatives/carers

There were no questionnaires returned from relatives/carers

7.0 Additional matters examined/additional concerns noted

Complaints

There was one complaint received between 1 April 2013 and 31 March 2014 which was resolved to the full satisfaction of the patient. There was evidence that this was managed in accordance with Trust policy and procedures.

Escalation meetings

An escalation meeting was held on the 23 February 2015 with the Assistant Director of Mental Health Services and the Patient Flow and Bed Management Coordinator. This was arranged to discuss the following concerns which have been incorporated into this report and recommendations have been made in relation to each area of concern.

- Lack of progress in implementing RQIA recommendations
- Absence of care planning in place in relation to patients assessed needs and deprivation of liberty on the ward
- Concerns in relation to reviewing of nursing care plans

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

Appendix 1

Follow-up on recommendations made following the announced inspection on 29 July 2013

No.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	It is recommended that where patients are unable or unwilling to sign care plans and reviews with their nurse that the reasons are clearly recorded with an indication of their ability to understand the process.	The inspector reviewed three sets of care documentation and was concerned to note that there was no evidence that patients had been involved in the development, implementation and review of their care plans. There was no record of patients' signatures or a record indicating why patients' signatures were not recorded on their care plans and reviews. There was no indication of the patients' ability to understand the process. This recommendation will be restated for a third time.	Not met
2	It is recommended that due to the lack of rehabilitation programmes resulting in patients remaining in an inappropriate environment the ward manager should ensure that all patient options are developed.	There was a fulltime occupation therapist working on the ward from Tuesday to Friday each week (8 a.m. to 6 p.m.) There was evidence in the progress notes that patients were involved in individual and group therapeutic activities on the ward. However, on the days of the inspector the occupational therapist was on annual leave and the inspector did not observe any therapeutic activities taking place on the ward. The inspector reviewed the nursing progress notes and there was no evidence that nursing staff carried out therapeutic activities on the ward. A new recommendation will be made in relation to this.	Fully met
3	It is recommended that due to the risk to patients and staff from passive smoking the ward manager ensures that all necessary arrangements are in place to reduce this risk.	This recommendation was made when the ward was in St Luke's Hospital Armagh. The ward has now relocated to Rosebrook ward which is a new purpose built building. The ward has an outdoor area for patients to access throughout the day. Patients can smoke in this area and there is wall mounted lighter available for patients.	Fully met
4	It is recommended that due to the lack of an appropriate secure space	This recommendation was made when the ward was in St Luke's Hospital Armagh which was located on the third floor and	Fully met

	for use by patients, the ward manager ensures that all necessary arrangements are in place.	therefore patients at this time were unable to access outdoor space directly from the ward. The ward has now relocated to Rosebrook ward which is a new purpose built building. Patients have access to an outdoor garden area and an open air courtyard.	
5	It is recommended that the Trust review the staffing levels for the ward to ensure safety and well-being of patients that are consistent with best practice.	The inspector was informed by the ward manager that the Trust have recently completed a review of the staffing levels on all wards across the bluestone site (Telford Study). A project is currently in place to recruit staff to the ward. On the day of the inspection there were no concerns noted regard staffing levels for the ward.	Fully met
6	It is recommended that the trust make arrangements to provide the ward with consistent Occupational Therapy services.	There is a fulltime occupation therapist working on the ward from Tuesday to Friday each week (8 a.m. to 6 p.m.) There was evidence in the progress notes that patients were involved in individual and group therapeutic activities on the ward.	Fully met
7	It is recommended that the ward manager ensures that individual activity programmes are developed for each patient.	There was no evidence in the three sets of care documentation reviewed by the inspector of individual activity programmes set up for patients on the ward. This recommendation will be restated for a second time	Not met
8	It is recommended that the ward manager ensures patient meetings are held regularly and documented.	The inspector reviewed records of patient meetings which should be held on the ward each week (Sunday) as documented in the previous quality improvement plan. However, records indicate that there were no meetings held from January 2014 to September 2014 and since September meetings had been held approximately once a monthly basis. This recommendation will be restated for a second time	Not met
9	It is recommended that the ward manager regularly holds team meetings which are recorded showing issues raised, actions taken and	The inspector reviewed minutes of team meetings held regularly on the ward which detailed issues raised actions taken and outcomes.	Fully met

	outcomes		
10	It is recommended that the complaints policy is updated.	The inspector reviewed the complaints policy which had been updated and was due to be reviewed again in July 2015	Fully met
11	It is recommended that all care-plans are signed by the registered nurse and the patient.	The inspector reviewed three sets of care documentation and there was evidence that the care plans had been signed by the nurses but there were no care plans signed by the patients. With regard to patients signing their care plans this will be restated for a third time as detailed above	Partially met

Appendix 1

Follow-up on recommendations made following the patient experience interview inspection on 28 July 2014

No.	Reference.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	5.3.3 (a) 6.3.2 (b)	It is recommended that the ward manager ensures that staff consistently explain the detention process to patients and that this is documented explicitly in case notes. (1)	The inspector reviewed three sets of care documentation and there was evidence that the patients' rights had been explained to them with regard to the detention process. The inspector also reviewed information which was available to patients on the ward which explained the detention process.	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 manager ensures a record of all staff who obtain the key to the safe where patient's money is stored is maintained, including the reason for access	The nurse on charge holds the safe key. A record is kept of the reasons why the safe has been opened and this is 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.	SAI No	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	SAI ID31743 & ID31665	The Trust must implement the Regional Search Guidelines (February 2014) with associated training and issue search wands to the relevant areas.	The inspector was advised by the ward manager that the Trust has implemented training in relation to the Regional Search Guidelines. This training is now included as part of the MAPA training. MAPA training now includes training on seclusion and the regional search guidelines. The inspector reviewed training records and	Fully met

			there was evidence that all staff on the ward had up to date MAPA training. Search wands are available to the ward.	
2		The Search Policy being developed to support the Regional Guidelines should include guidance in relation to searching patient possessions prior to a transfer between wards. This should be person specific, risk assessed and documented in the patients risk management plan.	The inspector was informed by the ward manager that the search policy is out for consultation and should be in place by April 2015. The inspector was informed that this policy includes guidance in relation to searching patient possessions prior to a transfer between wards. The Trust will ensure that this is implemented on the ward	Fully met
3		All staff working within Mental Health inpatient wards must wear a personal attack alarm.	The inspector was advised by the ward manager that all staff have personal attack alarms. This was also confirmed by staff on the ward. The ward manager advised that the ward has order another 12 alarms to ensure bank/agency staff have alarms when they are working on the ward and to ensure that each permanent member of staff has their own alarm.	Fully met
4		The Trust should review it's processes for the allocation / collection of personal attack alarms within mental health inpatient wards.	There was evidence on the ward that staff members sign their alarms in and out each day. All members of staff have access to an alarm when working on the ward and plans are in place for each member of staff to have their own individual alarm as 12 new alarms have been ordered.	Fully met
5		The Trust should give consideration to conducting joint patient assessments (where feasible/practical) and where specific identified patient concerns warrant same.	All patients are assessed on admissions to the to the PICU ward by two members of staff, the nurse on duty and the doctor.	Fully met
6		The Trust would welcome regional guidance in relation to the removal of violent and deranged persons from HSC facilities into PSNI custody and the role/authority of the Forensic Medical Officer (FMO) in such circumstances. The Trust should therefore request the HSCB to liaise with relevant agencies regarding this issue.	The patient flow and bed management coordinator informed the inspector that the Trust had written to the HSCB regarding this however they have had no further communication form them on this matter.	Fully met

7		The Trust should write to the PSNI regarding this case to highlight the issue of the importance of thorough search processes.	The patient flow and bed management coordinator informed the inspector that the Assistant Director had written to the PSNI regarding this case to highlight the importance of thorough search processes	Fully met

R3

Quality Improvement Plan

Unannounced Inspection

Rose Brooke PICU, Craigavon Area Hospital

12 and 13 February 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 patient flow and bed management coordinator on the day of the inspection visit.

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

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
1	5.3.3 (b)	It is recommended that where patients are unable or unwilling to sign care plans and reviews with their nurse that the reasons are clearly recorded with an indication of their ability to understand the process.	3	Immediate and ongoing	Care plans are audited weekly and where there are defecits identified the Senior Nurse direclty communicates to the Nurse involved. If a patient is unwilling or unable to sign their care plan then this will be clearly indicated. A Senior Nurse has implemented doucmentation to clearly state if a patient has signed their care plan and if not why. This documentation references the Comprehensive Risk Assessment update with a care plan update so all updates are clear and concise. We are in a transistional period at present as we move to the PARIS system which when fully implemented will have accurate updates and dates to enable clear auditing. We will be using documentation which will show a clear record of the patient having read their care plan and weekly review sheet and if the patient has signed and if not why.
2	6.3.2 (g)	It is recommended that the ward manager ensures patient meetings are held regularly and documented.	2	Immediate and ongoing	There is a Nurse delegated who will ensure this will happen weekly and who will ensure the minutes are completed. The nurse will attend these meetings when on duty and if not delegate to another member of staff. The Ward Occupational Therapist will also ensure these meetings will

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
					take place weekly. The Advocate has met with the Ward Occupational Therapist and will join the meeting every second week. The meetings will take place on a Tuesday.
3	5.3.1 (a)	It is recommended the ward manager ensures that the outcome of capacity assessment is recorded in the patients' care plans. This should detail the patients' capacity to make specific decisions and how future plans will be made in relation to this.	1	Immediate and ongoing	It is assumed that all patients have capacity unless otherwise stated. This is recorded in the patient record. If capacity issues have changed this will be noted on the weekly review sheet and in the patients case notes and the MD team will pursue the relevant capacity assessment and care plan.
4	5.3.1(a)	It is recommended the multi-disciplinary team reviews the MDT template to ensure that ongoing assessment of the patients' capacity to consent is recorded .	1	15 May 2015	The unit documentaiton is currently moving to the PARIS system we will continue to use the MD team review sheet where capacity and consent is reviewed and recorded weekly or more often should the patients' capacity needs change. The review sheet cleary identifies capacity and consent.
5	5.3.1 (f)	It is recommended that the multi-disciplinary team ensures that each section of the MDT template is completed in full. This should include details of patients	1	Immediate and ongoing	This will be addressed and recorded fully, this will be monitored by the ongoung audit that is being carried out on patient records.

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
		attendance/non-attendance with the reasons why and the agreed outcomes/actions of the meeting.			
6	5.3.1(a)	It is recommended that the ward manager ensures that patients have comprehensive assessments and MDT care plans in place.	1	31 May 2015	Patients are generally transferred to Rosebrook and not admitted directly and the comprehensive assessments are generally completed prior to transfer. The MD Team continue to assess and review and update assessments through out the patients admission to Rosebrook. The PQC comprehensive risk assessment is updated at least weekly. Since moving onto the PARIS system we will be using the recovery care plan. All members of the team will input to the recovery care plan. Care plans are being reviewed and audited against the RQIA recommendations and care plans will address any issues associated with DOLS and specifically the use of restrictive practice.
7	5.3.1 (a)	It is recommended that the ward manager ensures that care plans meet the assessed needs of patients including patients admitted in accordance with the Mental Health (Northern Ireland) Order 1986.	1	Immediate and ongoing	Care Plans are being audited weekly by senior staff and this recommendation forms part of the audit. The audit findings are commuincated directly back to the team/person responsible. Audit findings are discussed with the Ward Sister and Patient Flow and Bed Management Co-Ordinator.

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
8	5.3.3 (b)	It is recommended that the ward manager ensures all care plans are reviewed regularly. Multi-disciplinary team decisions regarding changes in care plans should be documentation with the involvement of the patient.	1	Immediate and ongoing	The staff have complied appropriate care plan update documentation which reflect changes to care plans and patient involvement. The PARIS documentaion should help the team ensure the recommendation is met fully.
9	6.3.2 (b)	It is recommended that the ward manager ensures that the information booklet for the ward is made available to relatives/carers.	1	Immediate and ongoing	The information booklet is available in the reception area. Relatives and Carers will be directed to it for reference.
10	6.3.1 (a)	It is recommended that the Trust reviews the arrangements in place for visitors on the ward, so that more than one patient can see their relative/carer at one time.	1	30 June 2015	Rosebrook has to balance the arrangements for visitors with the need to protect them in a specialist environment. The staff work with relatives to achieve this. Visitors ring to book their time with their relative or friend and we have and the ward staff strive to be flexible so that patients have time with their family and friends. There have been occasions when two sets of visitors have arrived at the same time and we have utilised the reception area which is private, the ward provides 4 chairs and a coffee table arranged in reception to accommodate extra visitors. Staff ensure our visiting areas are equipped with suitable furniture to meet the needs of our patients. The visitors room also contains CCTV monitoring as does the reception area. Staff are

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
					flexible to ensure patients are able to see their visitors and staff also take this oportunty to speak with relative about the care being given to the patient. A Rosebrook nurse is currently developing documentation to encourage a flow of communncation between carers and relatives.
11	5.3.1 (a)	It is recommended that the ward manager ensures that nursing staff have protected time to complete nurse led activities with patients. These activities should be available to patients during the day, in the evenings and at the weekend.	1	Immediate and ongoing	Nursing staff continue to carry out activities with patients. Nursing Staff record this and staff will ensure all documentaion is completed.
12	5.3.1 (a)	It is recommended that the ward manager ensures that patients have individualised assessments completed for therapeutic and recreational activities and that an individual timetable is set up from these assessment. These records should be maintained in the patients care documentation and not in a separate file to ensure ongoing monitoring and evaluation.	1	31 May 2015	The PARIS system will ensure all assessments and care plans/programmes of activity or timetables are recorded on the recovery care plan.
13	6.3.2 (b)	It is recommended that the ward	1	Immediate	The Ward Sister will ensure that patients are advised as to

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
		manager ensures that information in relation to the Mental Health (Northern Ireland) Order 1986 making a compliant and the advocacy service is available on the ward as well as the activity room		and ongoing	how to access information about the MHO 1986, how to make a complaint and how to access the advocacy servise.
14	5.3.1 (a)	It is recommended that the ward manager ensures that the patients care is assessed and plans are set up in accordance with the Deprivation of Liberty Safeguards (DOLS) – Interim Guidance, as outlined by the DHSSPSNI in October 2010.	1	30 April 2015	This is an issue that is being looked at by the unit as a whole. Within Rosebrook and the Blustone we have commenced a care plan group. Within this we are looking at DOLS. We have some staff trained who will lead this group. Staff training is to be organised across the Bluestone Unit by the Head of Service. The Trust has commissioned education days from the CEC on DoLs / Capacity careplanning. These will take place over 4 days between 1 May and 7 July 2015
15	5.3.1 (a)	It is recommended that the ward manager ensures that when restrictive practices are in place, individualised care plans are developed detailing the rationale for the level of restriction in terms of necessity and proportionality. Consideration of the impact on patient's human rights should be	1	31 May 2015	Individualised care plans are being developed with regards to restrictive practices. The operational guidelines have also been reviewed and updated.

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
		included in these care plans.			
16	4.3 (m)	It is recommended that the ward manager ensures that staff receive training in relation to restrictive practices and deprivation of liberty.	1	30 July 2015	The Trust has commissioned education days from the CEC on DoLs / Capacity careplanning. These will take place over 4 days between 1 May and 7 July 2015
17	7.3 (a)	It is recommended that the Trust reviews access arrangement into the ward to ensure visitors are able to access the ward in a timely manner.	1	30 July 2015	It has been identified that when staff with patients in patient areas they can not always hear the door buzzer. The purchasing staff to contact the company who installed the buzzer to increase the buzzer volumne so it can be heard through out the ward.

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	Wendy Kelly
NAME OF CHIEF EXECUTIVE / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Micéal Crilly

Inspector assessment of returned QIP				**Inspector**	**Date**
		Yes	**No**		
A.	Quality Improvement Plan response assessed by inspector as acceptable	x		Audrey McLellan	**22/4/15**
B.	Further information requested from provider				