The Regulation and Quality Improvement Authority

RQIA

Mental Health and Learning Disability

Unannounced Inspection

Waterside Hospital, Ward 2

Western Health and Social Care Trust

15 and 16 December 2014

national preventive mechanism

informing and improving health and social care

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Contents

1.0 General Information 3

2.0 Ward Profile 3

3.0 Introduction 4

3.1 Purpose and Aim of the Inspection 4

3.2 Methodology 4

4.0 Review of action plans/progress 6

4.1 Review of action plans/progress to address outcomes from the previous unannounced inspection 6

4.2 Review of action plans/progress to address outcomes from the previous financial inspection 6

5.0 Inspection Summary 7

6.0 Consultation Process 8

7.0 Additional matters examined/additional concerns noted 9

8.0 RQIA Compliance Scale Guidance 10

Appendix 1 Follow up on previous recommendations 181

Appendix 2 Inspection Findings 11

1.0 General Information

Ward Name	Waterside Hospital, Ward 2
Trust	Western Health and Social Care Trust
Hospital Address	Gransha Park Clooney Road BT47 6WH
Ward Telephone number	028 7186 0007
Ward Manager	Winifred O'Kane
Email address	winifred.okane@westerntrust.hscni.net
Person in charge on day of inspection	Winifred O'Kane
Category of Care	Dementia assessment and treatment ward
Date of last inspection and inspection type	27 August 2013 Unannounced
Name of inspector	Audrey Woods

2.0 Ward profile

Ward 2 is a ten bedded ward situated in Waterside hospital. The purpose of the ward is to provide assessment and treatment to male and female patients with a diagnosis of dementia.

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

Patients within ward 2 receive input from a multidisciplinary team which includes two consultant psychiatrists; a behaviour nurse specialist, nursing staff and a psychologist. Patients can access occupational therapy, physiotherapy and speech and language therapy by referral. A patient advocacy service is also available.

The ward has ten beds which includes an emergency bed. On the days of the inspection there were nine patients on the ward.

Ward 2 patients have recently moved from ward 1 as part of the reconfiguration of the hospital. This ward was spacious and decorated to promote a dementia friendly environment. The rooms were painted bold colours to help promote independence for patients with memory loss. The ward consisted of a four bedded bay area, one double room and four single rooms. The ward was well lit, well maintained, clean and fresh smelling. There was clear signage on entry to the ward. Information leaflets were available to patients and their families, which included information on the independent advocacy service and how to make a complaint. Information on who was on duty was also displayed. The ward was decorated for Christmas and appeared homely. There were two areas for visitors to meet with patients in private. Bathrooms were clean, tidy and clutter free.

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 Ward 2 Waterside was undertaken on 15 and 16 December 2014.

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

The recommendations made following the last unannounced inspection on 13 August 2013 were evaluated. The inspector was pleased to note that eight out of the nine recommendations had been fully met and compliance had been achieved in the following areas:

- All care plans had been reviewed to include actual or perceived deprivation of liberty
- The mobile phone policy had been reviewed
- The outdoor smoking structure in ward 1 had been risk assessed in relation to the ligature points
- The ward manager had reviewed the assessment and care planning process.
- Patients and their representatives were fully involved in needs assessments and care planning including risk assessment and agreed management plans.
- The Trust had reviewed the provision of occupational therapy support on the ward and an occupational therapist will be in position in January 2015
- Staff had received formal appraisal meetings in accordance with policy and procedure.
- A new template was in place to record multi-disciplinary case conference meetings.
- A new procedure was in place to define the processes for auditing of records and record keeping. The ward manager was now using the NIPEC auditing tool.

However, despite assurances for the Trust one recommendation had not been met. 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

No recommendations were made following the patient experience interview on the 14 April 2014.

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

The recommendation made following the finance inspection on 8 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 ensures that a record of the staff member who obtains the key to the patients' safe is maintained including 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 implementation of the new 'Person-Centred Integrated Care Pathway for Dementia Assessment Unit'. This incorporated nursing and medical assessments, risk assessments, patient progress notes, care planning and discharge planning for each patient on the ward. It was good to note that care plans on the ward were now individualised and person centred. There was also evidence of progress made in relation to partnership working with patient's representatives.

Occupational therapy provision on the ward had also been reviewed by the Trust and an occupational therapist will be taking up post on the ward in January 2015.

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 that patients' capacity to consent to care and treatment was monitored and re-evaluated regularly throughout their admission to ward 2. This was recorded in the weekly multi-disciplinary case conference (MDCC) records and in the patients' progress notes. In the three sets of care documentation reviewed by the inspector there was a record in the patients care plans that they had a diagnosis of dementia and may be confused and disorientated. However, there was no clear record that patient's capacity to understand their needs in relation to their care and treatment on the ward had been assessed. A recommendation has been made in relation to this.

There was evidence in the three sets of care documentation reviewed by the inspector that staff had involved families and where possible patients in the development of patient care plans.

It was good to note that patients were met by the nursing and medical staff prior to the multi-disciplinary case conference meetings (MDCC) and if patients were not in attendance at the meeting, there was evidence that they were informed of the outcome along with their family members/carers. Patients were encouraged wherever possible to sign their MDCC record sheet which recorded the outcome of the meeting and the planned intervention. In the three sets of care documentation reviewed by the inspector, there was a record of the reasons why patients had not attended the MDCC meetings.

Patients family members/carers had signed the MDCC record which detailed the care interventions agreed at the MDCC.

Information was available on the ward in relation to The Mental Health (Northern Ireland) Order 1986, advocacy service, complaints, human rights and capacity to consent. However this information was not available to the patients in a format suitable to their individual needs. The inspector noted that each patient had a recreational and therapeutic care plan completed which correlated with each individual patient's daily schedule. However these schedules were also not in a suitable format that met each patient's individual communication needs. A recommendation has been made in relation to this . It was good to note that information in relation to the complaints procedure and information regarding the name of the patient's doctor on the ward, their named nurse as well as the wards visiting times and meals times was available in easy read format.

The inspector spoke with five nursing staff working on the ward on the days of the inspection. Staff demonstrated their knowledge of capacity to consent and informed the inspector of the steps they took to gain the patients consent to care and treatment.

The inspector reviewed care documentation relating to three patients on the ward on the days of the inspection. There was evidence that all three patients had a Person-Centred Integrated Care Pathway for Dementia Assessment Unit completed (ICP). This contained medical and nursing assessments that were completed with the patient and their family/carers when they were initially admitted to the ward. Families were also asked to complete a 'personal profile' of the patient. From these assessments a person centred care plan was developed. In the three sets of care documentation reviewed by the inspector, there was evidence that all care plans were person centred, individualised and had been developed in conjunction with the patient's families/carers which addressed identified assessed needs.

When completing the risk assessment section in the ICP in relation to 'behaviours that challenge' staff were prompted to complete various other assessments to ascertain why patients behave in certain ways. Assessments completed included the Abbey Sensory Assessment, the Cohen-Mansfield Agitation Inventory Assessment (CMAI), the Cornall Scale for Depression in Dementia screening tool and the Neuropsychiatric Inventory Assessment. These assessments were evident in the care documentation and were used to update the care plans for each patient. The inspector spoke to the behaviour nurse specialist for the ward who also provided a community based service. The specialist advised that they complete assessments with nursing staff on the ward and then assist in devising care plans with staff and family members/carers.

In the three sets of care documentation reviewed by the inspector there was evidence that risk assessments and care plans were reviewed at each MDCC meeting. However, in the risk assessments reviewed by the inspector there was evidence that family members had been involved in completing the

assessments but the section to record this had not been completed on the assessment form. A recommendation has been made in relation to this.

Patient involvement was evidenced in all three sets of care documentation reviewed by the inspector. This was documented in the patients' daily progress notes, in the MDCC records of patients, care plans, risk assessments and discharge planning meetings. There was a record of separate meetings set up with families when they were unable to attend the MDCC meeting. Care documentation reviewed detailed that patient's views had been sought prior to multi-disciplinary meetings. Staff had met with patients and their family members/carers after the meeting to discuss the outcome.

The five nursing staff interviewed demonstrated their knowledge of patients' communication needs. Staff were familiar with individual patient needs, their likes, dislikes and choices.

All three of the questionnaires returned prior to the inspections from relatives indicated that they were involved in decisions regarding their relatives care and treatment. It was good to note that all three relatives indicated that their relative had received excellent/good care on the ward.

The inspector completed a direct observation of the ward over the two day inspection period. The inspector observed therapeutic activities taking place for patients on the ward. There was evidence in the three sets of care documentation reviewed that therapeutic and recreational activities were monitored on a daily basis on the ward. Patients' participation or otherwise was documented and included details of patients' reaction to particular activities. These records were used to update and review the therapeutic and recreational care plans.

The ward also has a therapeutic and recreational group timetable in place. This timetable includes activities such as hairdressing sessions, music with an outside provider, reminisce with music, games, bingo, pampering time, nails, hair and beauty, daily newspaper reading and board games. Patients are able to attend to their spiritual needs as weekly holy communion is held on the ward. Once a month a harmony singer calls to the ward for a music sessions. The inspector was advised that additional day-care opportunities will be provided when the Hub/Day Care Unit attached to the ward is opened however a date has not been confirmed yet. At present there is no occupational therapy input on the ward for purposes other than to complete functional assessments for discharge planning. It is good to note that this has been reviewed by the Trust and the ward will have a fulltime occupational therapist working between the Hub and the ward setting in January 2015.

Staff that met with the inspector discussed the type of activities they provide with patients and were able to identify each patient's likes and dislikes. They advised that they try to find out what patients are interested in then devise a care plan around their interest/hobbies.

The inspector spoke to the behaviour nurse specialist and psychologist who are both in the process of piloting a programme on the ward with patients. They plan to identify which additional activities will be appropriate for ward based nursing staff to deliver on the ward. At present the behaviour nurse specialist and psychologist hold three 1 ½ hour sessions each week with patients on the ward.

The inspector observed staff actively engaging with patients. Communication and interaction was positive and all patients were treated with dignity and respect. Staff discreetly and promptly attended to patient's needs when assistance or support was required. Staff used good communication skills and distraction techniques which worked successfully.

Two advocates from the Alzheimer's society visit the ward approximately every two weeks. They speak to all patients on the ward and meet with new patients who have been admitted. If requested by relatives or patients, they can attend meetings to provide support. The three questionnaires that were returned prior to the inspection from relatives indicated that two relatives/carers were aware of the advocacy. One relative/carer did not answer the question.

An Information handbook was available on the ward for patients and their relatives /carers. This handbook contained information on why the patient had been admitted to the ward, their rights, the admission process, information regard the patients stay on the hospital i.e. personal property, meals, clothing, security, smoking, visiting hours, children visiting, safety and privacy, religious service, mail, advocate, information on the Mental Health Review Tribunal, patients mental health, physical health, assessment, treatment, medication and observations. There was also information on the multi-disciplinary team and each professional's individual role, therapies available, ward activities, leaving the ward, home leave, and discharge arrangements. There was information on how to make a complaint and how to contact the Regulation and Quality Improvement Authority (RQIA). The inspector spoke to two relatives on the ward who advised that they had received this handbook.

Ward 2 is a locked ward therefore patients were not free to leave the ward. The inspector reviewed care documentation for three patients on the ward in relation to this deprivation of liberty. The inspector noted that there was deprivation of liberty care plans in place for this restrictive practice for all three patients. There was also reference to the human rights act in particular Article 5, right to liberty and security of person. There was evidence in the MDCC records that restrictions were reviewed weekly. However in two of the three sets of care documentation reviewed, the risks in the care plans in to support the deprivation of liberty had not been clearly outlined and recorded. A recommendation has been made in relation to this.

The ward has recently moved from ward 1 to ward 2 and in this new ward the patients do not have direct access outside to a garden area. Plans are in place to develop an enclosed safe garden space for patients to access throughout the day. However on the day of the inspection patients were not

able to access an outdoor area. If patients wished to access a garden area, they had to go outside of the ward with a member of staff to another area. A recommendation has been made in relation to this.

It was good to note that patients were able to go on visits outside of the ward with their families/carer when this was agreed at the MDCC. The inspector spoke to two family member who advised that they took their relative out for 'spins in the car' and to the local coffee shop. One patient still attended their local day centre in the community.

The five ward staff interviewed by the inspector demonstrated their knowledge and understanding of the Human Rights Act and Deprivation of Liberty Safeguards – Interim Guidance DHSSPS 2010.

There was reference throughout the care document reviewed by the inspector of the potential impact of the restrictive practices on the patients' human rights article 5, 8 and 14. There was no reference to articles 3 in the care documentation however when the inspector discussed patients human rights with staff on the ward they all demonstrated a good understanding of how they would ensure patients human rights were upheld in relation to article 3.

The ward manager advised the inspector that discharge planning commences on admission in accordance with policy and procedure and discharge plans are discussed at each MDCC. Separate discharge meetings are held with families/carers and patients when patients are deemed ready for discharge. The inspector reviewed one set of care documentation where the patient was ready for discharge. The MDCC records evidenced plans were in place and there was evidence that the professionals had met with the patient and their family to discuss discharge plans.

All three sets of care documentation reviewed by the inspector had an individualised discharge 'formulation' assessments in place which was reviewed regularly depending on changing needs. This assessment along with the patients 'personal profile assessment' is forwarded to the identified community placement as part of the discharge plan. These assessments assist in enhancing a patient centred approach to the transition into the community through the sharing of valuable information. When patients are discharged, the consultant provides the patients with a 4-6 week review follow up appointment. The behaviour nurse specialist provides a weekly follow up for 4 weeks and will then discharge the patient or if deemed necessary continue to provide support to the patient in the community.

MDCC records evidenced the input from the behaviour nurse specialist and psychology to support and prepare patients for discharge.

The ward manager advised that there was one patient on the ward whose discharge from hospital was delayed. A community placement has been identified and agreed by the family as a suitable placement however the placement would not be ready until February 2015.

The inspector was informed that when a placement has been identified, staff from the new facility visit the patient on the ward to familiarise themselves with the patient and their care plans.

Details of the above findings are included in Appendix 2.

On this occasion ward 2 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	1
Ward Staff	5
Relatives	2
Other Ward Professionals	3
Advocates	0

Patients

The inspector spoke to one patient on the ward. This patient stated they knew why they were in hospital and knew what they could and could not do on the ward. They said that they had been involved in their care and treatment and felt that the staff were all "great". When asked about their overall care on the ward this patient stated "it's lovely, beautiful, nurses are hands on and if you need anything they come straight away it's like a hotel". This patient was aware that there was an advocacy service on the ward but stated they had not needed this service. This patient stated that they attend day opportunities during the week from the ward which they avail of when in the community. The patient talked about going to other wards to meet other patients and to watch the television.

Relatives/Carers

The inspector spoke to two relatives on the days of the inspection. Both relatives stated that they were very pleased with the overall care and treatment their family member was receiving on the ward. They stated that the staff were providing a "good quality of care", "the nurses are great on the ward and the care is excellent". Both relatives advised they were updated regularly on their relatives care and treatment and had attended multi-disciplinary care conferences on behalf of their relative. Both relatives spoke about how they can bring their relative out in the car for a spin or over to the coffee shop on the hospital grounds. One relative advised that they had attended the carers group meetings on the ward and had found this very helpful.

Ward Staff

The inspector met with five nursing staff on the ward. All staff stated they felt well supported on the ward by the ward manager and stated that they enjoyed working on the ward. Staff stated that they felt the ward had a good team and stated that they all work well together. All staff advised that the ward works very closely with patient's 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. Nursing staff stated that patients were well cared for and that the ward had good therapeutic programmes in place for patients which were individual to each patient's need. 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 inspectors met with one of the consultant psychiatrists for the ward. The consultant informed the inspector that the patient's capacity to consent to care and treatment is reviewed on an ongoing basis. The consultant advised that they attend the ward three times each week to review patients care and treatment. There is also another consultant and a senior house officer working with patients on the ward. Both consultants attend a ward round each week which are held on Monday and Tuesday.

The inspector also met with the psychologist and behaviour nurse specialist for the ward. They advised that they are currently holding pilot sessions on therapeutic/recreational activities three times a week with patients on the ward. The plan is that when an agreement has been reached on which therapeutic activities will be most suitable to the patients on the ward, nursing staff will continue to deliver these activities with their guidance. They are also holding carers group meetings every 2 weeks for eight weeks and these sessions are held in the hub attached to the ward. The psychologist advised that they attend the ward rounds each week and they also have community based work they carry out. The behaviour nurse specialist works closely with ward based nursing staff to complete assessments. When patients are discharged the behaviour nurse specialist continues to support the patients in the community on follow up visits for four weeks. At this point the patients are reassessed and if continued support is required this is provided and if not the patients are discharged.

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	3	0
Other Ward Professionals	2	2
Relatives/carers	7	3

Ward Staff

No questionnaires were returned from ward staff

Other Ward Professionals

Two questionnaires were returned by other ward professionals in advance of the inspection. It was noted that information contained within the professional's questionnaires demonstrated that both had received training in capacity to consent and were aware of the Deprivation of Liberty Safeguards (DOLS) – interim guidance. One professional stated they had received training in restrictive practices and both staff indicated they were aware of restrictive practices on the ward. One professional stated they had received training in the areas of human rights.

One ward professional indicated they had received training on meeting the needs of patients who need support with communication. Both professionals indicated that patient's communication needs are recorded in their assessment and care plan. The two professionals indicated that they were aware of alternative methods of communicating with patients and stated these methods were used on the ward. They reported that the level of therapeutic and recreational activities on the ward could be further enhanced. The inspector spoke to these professionals when completing the inspection. Both professionals stated that they felt the patients will be provided with increased levels of therapeutic/recreational activities on the ward when the occupational therapist commences their post in January 2015.

Relatives/carers

Three questionnaires were returned by relatives/carers in advance of the inspection. All three relatives questionnaires stated that they felt the care on the ward was good or excellent. Relatives/carers stated that, "we find the care on the ward good and staff are approachable", "The nurses are always free to answer any questions or concerns we have". All three relatives/carers stated that they had been given the opportunity to be involved in decisions in relation to their relatives care and treatment. Two out of the three relatives/carers stated that their relatives had an individual assessment completed in relation to therapeutic activities. Two of the three questionnaires returned indicated that their relative participated in therapeutic and recreational activities and one questionnaire returned stated that they were "not aware" of this.

7.0 Additional matters examined/additional concerns noted

Complaints

Inspectors reviewed complaints received by the ward between 1 April 2013 and 31 March 2014. One complaint from a relative was recorded over this period of time and had been fully resolved to the satisfaction of the relative.

Mandatory Training

The inspector reviewed the mandatory training on the ward. There was evidence of deficits in the completion of mandatory training for some staff on the ward. Deficits were noted in fire awareness training (54% deficit), management of behaviours that challenge (17% deficit) and basic life support (46% deficit). A senior trust manager and the ward manager provided assurances at the conclusion of the inspection on 16 December 2014 that mandatory training for all members of staff on the ward will be addressed in full by 31 January 2015. RQIA have corresponded in writing to the Chief Executive of the Western Health and Social Care Trust (WHSCT). Requesting that confirmation is received by 1 February 2015 that all staff working on the ward will have attended relevant training and have the necessary skills and knowledge to fulfil their roles and responsibilities. A recommendation will however be made in relation to this.

Lack of progress in implementing RQIA recommendations

The inspector reviewed recommendations made following the last inspection in August 2013. The inspector was concerned to note that a recommendation relating to the comprehensive and systematic review of Trust policies and procedures had not been met at this inspection and therefore will be restated for a third time. The inspector reviewed the policies and procedures on the ward and there were 64% that had not been reviewed within the last three years. This matter was also raised with the Chief Executive of the Western Health and Social Care Trust. RQIA have requested that confirmation is received by 1 February 2015 that the relevant policies and procedures will be subject to review and disseminated to staff, as a matter of urgency. This recommendation will be restated for a third time.

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 unannounced inspection on 27 August 2013

No.	Reference.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	6	It is recommended that the ward manager ensures care plans in relation to actual or perceived deprivation of liberty are reviewed to ensure that an explanation of deprivation of liberty is included and relevant to the plan of care.	The inspector reviewed three sets of care documentation and all care plans in relation to actual or perceived deprivation of liberty had been reviewed. Each care plan explained the deprivation of liberty which was relevant to the plan of care. However in two sets of care documentation the risks in relation to the deprivation of liberty had not been clearly defined. A new recommendation will be made in relation to this.	Fully met
2	16(Section 4)	It is recommended that the Trust ensures that the policy for the use of mobile phones and chargers is expanded to clarify the possibility that chargers may not be returned to patients, and agrees and fully implements the procedure. The ward manager must ensure that associated risk assessments are available in patients' care plans.	The WHSCT mobile phone policy was reviewed in May 2014. This policy now details that chargers will be removed on admission and stored by nursing staff for safe keeping due to the potential ligature risks. The policy details that all mobile phones can be charged as and when requested at a central point. At the time of the inspection one patient on the ward had a mobile phone but had requested for their relative to keep the charger at home to be brought in when needed. The ward manager advised that if chargers are removed from patients a risk assessment would be completed and a record held in the patient's care documentation.	Fully met
3	16(Section 4)	It is recommended that the Trust undertakes a risk assessment of the outside smoking structure in	The inspector reviewed the smoking structure and ligature points had been removed. A copy of the risk assessment and action plan has been forwarded to RQIA	Fully met

		relation to ligature points and addresses any remedial action points as a matter of urgency. A copy of the completed risk assessment and any related action plan must be forwarded to RQIA by 27 September 2013.		
4	20(Standard 43)	It is recommended that the ward manager reviews the assessment and care planning processes and records to ensure the following: • Care plans and risk management plans relevant to the assessed need are developed; • Care plans are individualised and person-centred; • Capacity and consent issues are clearly and consistently documented; Patients and/or their representatives must be fully involved in needs assessment and care planning, including risk assessments and agreed management plans.	The inspector reviewed three sets of care documentation and there was evidence that care plans and risk assessments had been developed. The care plans were individualised and person centred. There was clear and consistent evidence of capacity to consent issues documented throughout the three sets of care documentation. There was evidence in the three sets of care documentation reviewed by the inspector that patients and /or there representative had been fully involved in needs assessments and care planning including risk assessments and agreed management plans	Fully met
5	9 (9.6)	It is recommended that the Trust	The Trust has reviewed the provision of therapeutic	Fully met

		reviews the provision of therapeutic occupational therapy support to the ward in order to provide a full multidisciplinary approach to care and treatment and a regular provision of occupational therapy.	occupational therapy support on the ward and an occupational therapist has been appointment. They are due to take up their post in early January 2015. Their role will be to provide support to the ward and to the Hub/Day Care Unit attached to the ward. This unit will be attended by patients on the ward and by service users from the community**.**	
6	17(4.3 (l))	It is recommended that the Trust ensures that all staff have formal performance appraisal meetings in accordance with policies and procedures.	The inspector reviewed appraisal records and there was evidence that all staff had had an appraisal meeting and dates had been set for the following year.	Fully met
7	17(4.3 (b))	It is recommended that the Trust ensures all policies and procedures are subject to a systematic and comprehensive three yearly review.	The inspector reviewed the policies and procedures held on the ward; 64% of policies and procedures held on the ward had been created prior to 2011 and therefore had not been reviewed within the last three years This recommendation will be restated for the third time	Not met
8	17(5.3 .1 (f))	It is recommended that the ward manager ensures the template for recording planning and outcomes of multi-disciplinary team meetings includes but is not limited to patient/relative views/involvement, names of those present, agreed actions and outcomes including responsibility for completion, agreed timescales for completion, and review of risks.	The inspector reviewed three sets of care documentation which all contained a template for recording multi-disciplinary team meetings which included patient/relative views/involvement, names of those present, agreed actions and outcomes including responsibility for completion, agreed timescales for completion, and review of risks.	Fully met

9	17 (4.3 (b))	It is recommended that the ward manager develops a procedure to define audit processes for auditing of records and record keeping, and ensures the procedure includes details of measurements used to benchmark results and actions plans to address identified deficits.	The ward manager is using the Northern Ireland Practice and Education Council (NIPEC) - Improving Record Keeping Electronic Audit Tool to audit records and record keeping. This process is completed very three months with the Acting Head of Service and Lead Nurse for Older Peoples Mental Health. This tool contains four sections to audit which include: Mandatory Requirements, Admission and Risk Assessment, Care Planning and Discharge Planning. Percentage scores are calculated for each section and an overall score is calculated. These result can then be used to develop action plans to address identified deficits with the named nurse.	Fully met

Appendix 1

Follow-up on recommendations made at the finance inspection on 8 January 2014

No.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	It is recommended that the ward manager ensures that a record is of the staff member who obtains the key to the patients' safes is maintained, including the reason for access.	The staff member on charge holds the safe key. The reason for access to the safe is recorded and 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	N/A	N/A		

The Regulation and Quality Improvement Authority

Quality Improvement Plan

Unannounced Inspection

Waterside Hospital, Ward 2

15 and 16 December 2014

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

The specific actions set out in the Quality Improvement Plan were discussed with the acting head of service and lead nurse for olders peoples mental health, the nurse in charge and a staff nurse on the ward 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.

1	4.3 (j)	It is recommended that the Trust ensures all policies and procedures are subject to a systematic and comprehensive three yearly review	3	15 March 31	This has been escalated through the Trust Governance processes and is being tabled at the Trust Quality and Standards meeting to agree an action plan and timescale to address this issue.
2	5.3 (a)	It is recommended that the ward manager ensures that all care plans include the outcome of the patient's capacity assessments.	1	31 January 2015	Specific capacity assessments are completed at the weekly Multi-Disciplinary care conference. The outcomes are incorporated into patients individual care plans and reflect associated articles of the Human Rights Act 1998. Completed
3	6.3.2 (c)	It is recommended that the ward manager ensures that information relating to patient's rights, relevant ward and Trust policies and information relating to the ward should be made available in a format that may be more accessible and easily understood by patients with a cognitive impairment .	1	30 April 2015	–The Ward Manager will ensure all information will be available in suitable format and accessible in Ward 2 and Ward 1 by April 2015
4	5.3.3 (b)	It is recommended that the ward manager ensures that where risk assessments are completed in	1	Immediate and	All documentation contains the correct information and signatures of patient/carer. The NIPEC audit tool is carried out quarterly and verified Bi Annually

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

		conjunction with patients and their carers/relatives, the documentation is completed in full with the name of the person contributing to the assessment, in keeping with the Promoting Quality Care: Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability 2010		ongoing	by the Head of Service / Lead Nurse for Older People's Mental Health team. If there is any areas identified within the Audit an Improvement Plan is put in place to rectify and re-audit. The Audits are monitored by Head of Service / Lead Nurse and reported at the Directorate Governance meeting.
5	5.3.1 (a)	It is recommended that the ward manager ensures that care plans in relation to perceived or actual deprivation of liberty includes 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	31 January 2015	The Ward Manager confirms that the recommendation has been completed and care plans reflect individual risk and incorporate the associated articles of the Human Rights Act 1998. The Deprivation of Liberty guidelines for PCOP is being developed and will be in place by March 2015. This will be superseded by the new Capacity Bill.
6	6.3.1 (a)	It is recommended that the Trust reviews patient access to the garden area to ensure patients have direct access to an outdoor	1	31 July 2015	Although patients do not have direct access to the garden the patients do have opportunities to be accompanied to the garden and have walks in the grounds. Since the appointment of the

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

		garden space throughout the day.			Occupational Therapist in January 2015, patients attending the Hub have daily un-restricted access to the enclosed garden area. Currently seeking funding to make an area of the garden secure to allow unrestricted access by patients, therefore we request an extension to 31 July 2015.

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

[redacted]	W. O'Kane 25th February 2015.
	Elaine Hay

Inspector assessment of returned QIP		Yes	No	Inspector	Date
A.	Quality Improvement Plan response assessed by inspector as acceptable	X		AM'Lotter	5/3/15
B.	Further information requested from provider