The Regulation and Quality Improvement Authority

RQIA

Mental Health and Learning Disability

Announced Inspection

Cranfield Women's Ward

Muckamore Abbey Hospital

Belfast HSC Trust

9 July 2013

national preventive mechanism

informing and improving health and social care

www.rqia.org.uk

Disclaimer

Inspectors would like to thank Cranfield Women's Ward patients and staff for their cooperation and openness throughout the inspection process.

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1.0 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).

1.1 Purpose of the Inspection

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

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

- The Mental Health (Northern Ireland) Order 1986;
- 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.

1.2 Methods/Process

Committed to a culture of learning, 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.

On **3 May 2013** RQIA informed the Trust of the inspection date and forwarded the associated inspection documentation, 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 inspectors.
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 inspectors in preparing for this inspection.

The recommendations made during the previous inspection on **13 and 14 December 2010** were also assessed during this inspection to determine the Trust's progress towards compliance. The inspectors found compliance in the following areas,

- all patients on the ward have access to advocacy;
- learning from complaints across the hospital setting is shared with Cranfield Women's Ward staff;
- a ward welcome pack has been made available to patients. This pack includes information on the use of mobile phones and the trust's zero tolerance policy;
- assessments and care plans are completed for all new patients within six weeks of admission;
- patient views are sought and shared at the weekly multidisciplinary meeting;
- patients are informed of the outcome of the multidisciplinary meeting;
- daily staff/patient interactions are recorded;
- ensuite facilities have now been refurbished.

In spite of assurances from the Trust, one recommendation remained outstanding from the previous inspection. The previously stated recommendation that was outstanding has been added to the Quality Improvement Plan for action (reference Appendix 1).

An overall summary of the ward's performance against the human rights theme of Protection is in Section 3 and full details of the inspection findings are outlined in Appendix 2.

2.0 Ward Profile

Trust	Belfast HSC Trust
Name of hospital/facility	Muckamore Abbey Hospital
Address	1 Abbey Road Muckamore Co. Antrim BT41 4SH
Telephone number	028 95042063
Person-in-charge on day of inspection	Adrienne Creane
Email address	Adrienne.creane@belfasttrust.hscni.net
Nature of service - MH/LD	Learning Disability
Name of ward/s and category of care	Cranfield Women's Ward – Acute Learning Disability
Number of patients and occupancy level on days of inspection	15 (fully occupied)
Number of detained patients on day of inspection	11
Date of last inspection	13 and 14 December 2010

Cranfield Women's is a fifteen bedded female admission ward on the Muckamore Abbey Hospital site. The purpose of the ward is to provide assessment and treatment to female patients with a learning disability who need to be supported in an acute psychiatric care environment.

The ward is connected to the male acute admission ward and the intensive care unit in Muckamore Abbey Hospital – Cranfield Men's ward and Cranfield ICU. Access to the ward can be gained via a corridor linking all three Cranfield wards.

Patients within Cranfield Women's receive input from a multidisciplinary team which incorporates psychiatry; nursing; psychology; behavioural support; and social work professionals. A patient advocacy service is also available. Carer advocacy services are not available.

3.0 Inspection Summary

An announced inspection of Cranfield Women's Ward was undertaken on **9 July 2013**. The purpose of this inspection was to assess the ward's arrangements and procedures for safeguarding vulnerable adults.

The following is a summary of the inspection findings of the arrangements for safeguarding vulnerable adults on this ward and represents the position on the ward on the day of the inspection.

A review of training records available indicated that all the staff working on the ward on the day of the inspection had undertaken training in safeguarding of vulnerable adults.

Records available on the day of the inspection demonstrated that guidance on safeguarding of vulnerable adults procedures was not included in the induction programme.

Care documentation in relation to safeguarding of vulnerable adults referrals reviewed by inspectors evidenced that referrals had been made, forwarded to the safeguarding officer and reviewed. A number of referrals indicated that a 'protection plan' had been put in place however the 'protection plan' was not detailed on the vulnerable adult's referral documentation.

Inspectors were advised that safeguarding officers are automatically alerted if three vulnerable adult referrals are received for the same patient however this alert system does not alert safeguarding officer's to multiple referrals due to the same alleged perpetrator.

Care documentation relating to four patients was reviewed on the day of the inspection. There was evidence that patient needs were assessed and that intervention plans had been developed to address identified needs.

The care plans and risk assessments reviewed had not been signed by the patient or their relative.

Inspectors noted a number of practices on the ward on the day of the inspection that could viewed as restrictive however the rationale or therapeutic aim for these practices was not documented within care notes reviewed by inspectors.

Consideration of the potential impact on individual patient's human rights was not recorded in the care documentation reviewed.

Doors to the ward were locked however the reason for locked doors had not been fully outlined in the ward welcome pack, or in individual care plans.

Each patient's bedroom door has a lock – it was good to note that patients have access to the key for their bedroom and chose whether or not to lock it.

Patient valuables and small amounts of cash were stored in individual lockable drawers in the ward office. All transactions are countersigned. In addition, cash drawer balances are checked and signed for by two staff twice daily. Cash drawer balances are also audited on a weekly basis.

The policy for mobile phone use is under review. It was good to note that as an interim measure, a cordless telephone has been made available on the ward to enhance patient privacy while making/receiving calls.

Activity schedules were available within individual care plans and in the patient's bedroom.

Supervision, induction and training records for nursing staff were available on the ward. The records reviewed by inspectors evidenced that mandatory training was up to date for all nursing staff working on the ward on the day of the inspection.

At the time of the inspection, staff and management highlighted that the ward was a very stressful environment to work in. A number of staff highlighted concerns in relation to the level of aggression (both verbal and physical) directed towards them. Inspectors witnessed threats and several physical attacks to staff on the ward on the day of the inspection. Patients also raised this issue with inspectors.

Inspectors noted that nursing staff had not received supervision for a period of five months.

A number of staff indicated that they would like to receive additional training in relation to meeting specific patient needs. Inspectors were advised some training had been delivered by staff from clinical psychology department.

There was an organisational structure for the ward on display in the ward office at the time of the inspection. This information has also been outlined in the patient welcome pack for the ward. The patients and staff who met with inspectors on the day of the inspection were aware of the organisational structure for the ward.

The care notes reviewed by inspectors evidenced that patients detained under the Mental Health (Northern Ireland) Order 1986 had been made aware of their rights. This information was also available to patients on the ward in an easy to read format.

The ward welcome pack included easy to read information for patients including 'You, Muckamore Abbey and the Law'; 'Your Right to Confidentiality'; Keep me safe, treat me with respect'; and 'If you have a complaint, let's talk about it'.

Inspectors reviewed care documentation relating to four patients on the day of the inspection. Pre-printed care plans are used on the ward. Inspectors found that some information contained within care documentation reviewed

was not sufficiently personalised to the patient, lacked detail and did not always contain interventions or actions to address problems identified in the nursing assessment. The rationale for some interventions was not included in the care documentation reviewed.

Inspectors were shown the computerised reporting system (Datix) for recording and reporting accident, incidents and near misses. Referral to other members of the multi-disciplinary team had been made were necessary, including the Vulnerable Adults Safeguarding team.

On this occasion Cranfield Women's Ward has achieved an overall compliance level of **"moving towards compliance"** in relation to the human rights inspection theme "Protection".

4.0 Stakeholder Engagement

Questionnaires were issued to staff, patients, and relatives/carers in advance of the inspection. The responses from the questionnaires were used to inform the inspection process.

Questionnaires issued to	Number issued	Number returned
Patients	**25**	**0**
Carers/Relatives	**25**	**0**
Staff	**30**	**11**

During the inspection the inspectors had the opportunity to meet with staff, patients and advocates. Below are the details of the number of discussions held during the inspection.

Additional discussions during inspection	Number
Patients	**6**
Carers/Relatives	**0**
Staff	**8**
Advocates	**3**

The following information is a summary of feedback received from those who returned a questionnaire or met with an inspector during the inspection.

Patients: Inspectors met with six patients on the day of the inspection. On the whole, patient feedback was positive. Comments made by patient's to inspectors regarding care and treatment on the ward included
'Treated great, can speak to nurses if anything was wrong'.
'Feel safer here than I did in independent living'.
'I'm treated very good – with dignity and respect'.
Three patient's made disclosure's which resulted referral to safeguarding under vulnerable adults protection policy. RQIA have corresponded with the operational manager for this ward in relation to this.

Carers/ Relatives: The inspectors did not meet with any relatives or carers on the day of the inspection.

Staff: Inspectors met with eight staff on the day of the inspection and received 11 completed questionnaires. Three staff suggested 'clear and concise treatment plans' and 'medical staff to consult with nursing staff regarding changes to medication and treatment' as suggested areas for improvement on returned staff questionnaires.
Other suggestions for improvement included opportunities to attend additional training specific to patient needs, and additional support from senior management.

A number of staff indicated that working on the ward is rewarding but stressful place to work due to the level and frequency of verbal and physical aggressions.

Advocates: Inspectors met with three advocates for the ward on the day of the inspection. Advocates reported that they had good working relationships with hospital staff. Advocates highlighted that although there is a significant demand for advocacy services within the hospital, the availability of advocacy is limited due to funding – as a result, demand often outweighs capacity. It was reported that one trust has funded 10 hours per month for advocacy within Muckamore Abbey Hospital. Advocates raised some concerns regarding resettlement of patients from Muckamore to community facilities however this did not relate to patients in Cranfield Women's Ward.

5.0 Additional Concerns Noted by Inspectors (if applicable)

Inspectors were informed that a number of patient's on the ward were particularly unsettled and presenting with high levels of challenging behaviours at the time of the inspection. A number of reasons were cited for this to include:

- Patients for who discharge from hospital had been delayed. On the day of the inspection, discharge from hospital for eight of the fifteen patients on the ward was described as delayed. Staff shared their concerns regarding the impact that a delay in discharge has on patients.
- The absence of a forensic service for females with a learning disability in Northern Ireland;
- The absence of community based services to support patients with a learning disability as an alternative to being admitted to hospital or to support a more timely discharge from hospital (eg crisis response teams; home treatment teams);
- The limited availability of appropriate community facilities to support individuals with a learning disability who present with behaviours that challenge;
- The time delay between a patient having their Mental Health Review Tribunal Hearing and being notified of the decision of that tribunal.

6.0 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.

7.0 Summary of Compliance – RQIA Assessment

No.	Question	Compliant	Substantially Compliant	Moving Towards Compliance	Not Compliant	Unlikely to become compliant	Not Applicable
1	The ward has robust arrangements in place that ensure the safety and well-being of patients that are consistent with legislative and best practice guidance documents.			✓			
2	Patients' needs are accurately assessed; risks identified and responded to appropriately.			✓			
3	The ward safeguards patient rights in relation to the use of: (i) restrictive practice; (ii) isolation/seclusion; (iii) close observation; (iv) use of restraint				✓		
4	The ward provides patients with an appropriate range of therapeutic individualised and group activities.			✓			
5	The ward has robust processes in place to ensure the safety of patients' monies and property.		✓				
6	There are procedures in place for the effective management, support, supervision and training of staff.			✓			
7	There is an appropriate organisational structure for the ward that defines staff and management roles, responsibilities and the accountability arrangements.		✓				
8	Patients and their family/carers have access to appropriate information in relation to their rights, including information on how to make a complaint.		✓				
9	Care plans are written in an individualised and person-centred manner that is consistent with professional and legislative requirements.				✓		
10	Staff report accidents, incidents and serious adverse incidents in accordance with policies and procedures and regional guidance and follow these up appropriately.		✓				

Appendix 2 – Inspection Findings

The Inspection Findings are beow.

Inspection Standards.pdf

Inspection Standards – The organisation has appropriately trained staff and robust procedures to support and meet the needs of patients **Ward Self-Assessment**	
Statement 1. – **The ward has robust arrangements in place that ensure the safety and well-being of patients that are consistent with legislative and best practice guidance documents;** **The ward monitors these arrangements to ensure that they are appropriately and consistently applied;** **Staff ensure that vulnerable adult procedures are followed and all vulnerable adult issues are addressed promptly, appropriately and in accordance with local and regional policies and procedures.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
Senior Nurse Manager and Ward Manager continually review staffing ratios to ensure correct staff to patient ratio is in place to ensure the safety and wellbeing of both patients and staff. Person centred plans are provided for all patients to maintain their safety. If it is deemed necessary following discussion with the MDT patients also have up to date risk assessments for their patient's protection and that of others. All staff including bank receive mandatory training. Staff receive mandatory vulnerable adult training, this is updated every 3 years. All staff are Access NI checked prior to the commencement of employment. All staff receive an induction. A medical officer is available should any physical examinations be required. Staff adhere to the Trusts Vulnerable Adults Safeguarding Policy. If a vulnerable adult issue arises, staff follow the Vulnerable Adult Process. Staff are also aware of policies such as accident/incident reporting, whistleblowing, level of observations, restrictive practice, zero tolerance and complaints which are also important in ensuring the safety and well being of Patients. A proforma is signed to evidence staff have read new policies Corporate policies are available on the intranet, MH&LD policies are available in the ward.	Moving Towards Compliance

Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
Information relating to adult safeguarding including the Regional Adult Protection Policy and Procedure (2006) and other guidance documents were available on the ward. There was also a flow chart for staff reference displayed in the ward office. Staff interviewed by inspectors confirmed that they had undertaken training and were able to detail actions to be taken in the event of a safeguarding concern. Review of training records available indicated that all the staff working on the ward on the day of the inspection had undertaken training in safeguarding of vulnerable adults. Records available on the day of the inspection demonstrated that guidance on safeguarding of vulnerable adults procedures was not included in the induction programme. A recommendation has been made in relation to this. Care documentation in relation to safeguarding of vulnerable adults referrals reviewed by inspectors evidenced that referrals had been made, forwarded to the safeguarding officer and reviewed. A number of referrals indicated that a 'protection plan' had been put in place however the 'protection plan' was not detailed on the vulnerable adult's referral documentation. A recommendation has been made in relation to this. Inspectors were advised that safeguarding officers are automatically alerted if three vulnerable adult referrals are received for the same patient however this alert system does not alert safeguarding officer's to multiple referrals due to the same alleged perpetrator. A recommendation has been made in relation to this. Three patients' interviewed by inspectors on the day on the inspection made allegations of a safeguarding nature. The patients were subsequently referred as per the Belfast Health and Social Care Trust Adult Safeguarding Procedure. RQIA have corresponded with the trust to relation to this.	Moving towards compliance

Inspection Standards – Assessment of need and risk Ward Self-Assessment	
Statement 2. – **Patients' needs are accurately assessed, risks identified and responded to appropriately.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
The assessing of risk is part of the process of supporting patients and maintaining their safety. All patients have a promoting quality care (PQC) risk screening tool completed on admission, this is discussed by the MDT at a post admission meeting and a decision made re. the need for a Comprehensive Risk Assessment The Risk assessment helps provide staff with an early warning system and maximises the probability of a positive outcome. Nurses adhere to NMC guidelines which state the nurses must act to identify and minimise risk to patients. All patients have Person Centred Care plan, needs are identified, plans and interventions are put in place and evaluations/reviews take place as required and at a minimum of 6 monthly The Comprehensive Risk Assessment is reviewed when there is a change in the risk and at a minimum of 6 monthly Staff are trained in Promoting Quality Care Use of the Promoting Quality Care documentation minimises the risk and consequences of an adverse event. The Vulnerable Adult process is adhered to Post incident reviews/de briefings take place when required Ward manager approves all incidents recorded on datix and instigates an investigation if required	Substantially Compliant

Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
Care documentation relating to four patients was reviewed on the day of the inspection. Care and treatment is documented in a number of files (medical file, nursing file). There was evidence that patient needs were assessed and that intervention plans had been developed to address identified needs. Inspectors found that none of the care plans or risk assessments reviewed had been signed by the patient or their relative. Some patients or carers had signed the 'My Personal Detail Form'. A recommendation has been made in relation to this. Inspectors were informed that a template to record multidisciplinary meetings is currently being developed. A recommendation has been made in relation to this. At present, the ward sister does routinely audit or review care documentation. A recommendation has been made in relation to this.	Moving towards compliance

Inspection Standards – Awareness and application of safeguarding procedures Ward Self-Assessment	
Statement 3 . –The ward safeguards patient rights in relation to the use of: **(i) restrictions;** **(ii) isolation/ seclusion;** **(iii) close observation;** **(iv) restraint.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
kOn admission, restrictions on the ward, isolation/seclusion, level of observations and restraint are discussed with the patient and the family. Each should be documented in the patients care plan also stating the patients understanding of safeguarding procedures. Restrictions are identified, discussed with the patient and described in the patients care plan and risk assessment, if applicable. Patients are able to move around the building with a staff as they wish to. All staff adhere to the policy on seclusion. Seclusion is authorised by a Doctor and reported to the Duty officer and documented in the care plan. A seclusion care plan is also completed. Levels of observation are prescribed to protect the patient or others. Again this is prescribed by a doctor and documented in the care plan and is explained to the patient. This is reviewed as per policy. Physical Intervention is used as a last resort. An audit form is completed after each incident of physical intervention. Audit forms are reviewed by the MAPA team. All staff have up to date training in MAPA. The Trust has governance arrangements in place to monitor and review the use of physical interventions and seclusion and identify any subsequent trends. These reports are shared with ward staff and are available in the ward. It is important when working with people with learning disability/mental health problems to be aware that not all patients can understand these safeguarding procedures, this is addressed in the patients care plan. Independent advocates are available to support patients. Staff are aware of restrictive practices, physical Interventions, seclusion and level of observation policies. They are also available in the ward. Safeguarding procedures are discussed at the MDT meeting.	Moving Towards Compliance

Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
Inspectors noted a number of practices (for example patients being cared for in a locked ward) on the ward on the day of the inspection that could viewed as restrictive. The rationale or therapeutic aim for these practices was not documented within care notes reviewed by inspectors. 'Restriction checklists' had been completed for some practices however these checklists required two hourly review and did not include all of the practices that could be viewed as restrictive. Consideration of the potential impact on individual patient's human rights was not recorded in the care documentation reviewed. The rationale for patients being nursed on enhanced levels of observation had been documented in patient notes and agreed with the medical staff in line with policy and procedures. Doors to the ward are locked however the reason for locked doors had not been fully outlined in the ward welcome pack, or in individual care plans. Inspector's noted that a behavioural contract for one patient referred to 'house rules'. Inspectors were assured by both the ward sister and the patient that 'house rules' do not exist on the ward. Recommendations have been made in relation to this.	Not compliant

Inspection Standards – Provision and access to therapeutic activity Ward Self-Assessment	
Statement 4. – **The ward provides patients with therapeutic individualised and group activities;** **The daily programme that details professionals involved is available and accessible;** **Clear documentation is maintained.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
Patient's have access to therapeutic activities on a daily basis with nursing staff. Each patient is assessed on admission and an individual programme developed in the weeks following. More specific therapeutic activities are available through day care, i.e. the music therapist, art therapist and aroma therapist. Positive or negative responses are reported / recorded from each therapeutic activity in the care plan. An activity room is available in the ward Activities also take place in the dining area The ward uses day care facilities at the weekend for cookery sessions A swimming pool is available for patient use Psychology provide 1:1 sessions with patients Patients are referred to Behaviour Services when deemed necessary by the MDT Speech and Language therapy is available in the hospital.	Moving Towards Compliance
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
Activity plans were available within individual care plans and in each patient's bedroom. Ward based activities were scheduled as part of patient activity plans however, the nature of activity to be undertaken was not detailed. A schedule of ward based activities for patients not attending day care was not available at the time of the inspection. Information for patients relating to daily activities was not available in communal patient areas.	Moving towards compliance

Inspection Standards – The organisation operates effective procedures for managing patients' finances and property Ward Self-Assessment	
Statement 5. – **The ward has robust processes in place to ensure the safety of patients' monies and property.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
Staff adhere to Patients'/Clients' Private Property - written procedures for long-stay patients/clients. The document is available in the ward. Staff discourage patients from bringing in any valuables onto the ward in case of any breakage/theft/loss. Any valuables can be locked in the safe or patient's drawer. All personal belongings are documented on admission to the ward and on discharge. When withdrawing and entering monies into the cash drawer, this is signed by two members of staff as per procedure. All lodgements of cash are also be receipted. A trained staff checks the cash drawers daily. A weekly check also takes place Senior Nurse Manager check same monthly. All patients have individual, lockable bedrooms where they keep their personal belongings. This is individually assessed and outcome recorded in the care plan	Substantially Compliant

Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
Each patient's bedroom door has a lock – patients have access to the key for their bedroom and chose whether or not to lock it. Valuables and small amounts of cash belonging to patients was stored in individual lockable drawers in the ward office. All transactions are countersigned (patient and staff signatures or 2 x staff signatures). In addition, cash drawer balances are checked and signed for by two staff twice daily (morning and night handovers). Cash drawer balances are also audited on a weekly basis. Patient property is documented on admission; when going on leave and on discharge. The policy for mobile phone use on the ward was under review. As an interim measure, a cordless telephone has been made available on the ward to enhance patient privacy while making/receiving calls.	Substantially Compliant

Inspection Standards – There are procedures in place for the effective management, support, supervision and training of staff. **Ward Self-Assessment**	
Statement 6. – **The ward has a training and development plan in place to address the training needs of all staff ;** **Records of training evidence that all staff have attended mandatory training in accordance with policies, and training plans;** **Staff have the necessary skills knowledge and competence for the role they undertake;** **All staff have formally recorded supervision meetings in accordance with policies and procedures;** **All staff have formally recorded annual performance appraisal meetings;** **Additional support is provided for staff through various mechanisms, such as regular ward meetings.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
The ward provides a positive and professional working environment which promotes good teamwork. Staff benefit from peer support together with support from the Ward Manager, Deputy Ward Sister and Senior Nurse Manager who are approachable/understanding and always available for support/advice or reassurance. Clinical Supervision is completed twice yearly and PCPs annually. Training Records are kept in a file specifically for courses so that routine checks can be kept. Mandatory training is kept up to date Monthly training records are forwarded to the Nurse Development Lead. The HRMS is a database available for all hospital staff's records. The Nurse Development Lead provides any information related to courses. Courses are booked through TAS or the Beeches website. The Manager of the Nurse Bank is responsible to organise bank staff training. The ward promotes the Trust's core value of learning & developing and sustains a learning culture and aims to empower people through development and support. Ward meetings take place regularly	Moving Towards Compliance

Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
Supervision, induction and training records for nursing staff were available on the ward. The records reviewed by inspectors evidenced that mandatory training was up to date for all nursing staff working on the ward on the day of the inspection. At the time of the inspection, staff and management highlighted that the ward was a very stressful environment to work in. Inspectors were concerned to note that nursing staff had not received supervision for a period of five months. Inspectors were informed that this was due to a pending change in the format for nursing supervision and the need for all staff to undertake training prior to the implementation of same. A recommendation has been made in relation to this. It was noted that bank staff work on the ward on a regular basis. The training records for bank staff were not available on the ward. A recommendation has been made in relation to this. A number of staff indicated that they would like to receive additional training in relation to specific patient needs for example working with patients with a personality disorder. Inspectors were advised some training had been delivered by staff from clinical psychology department. A training plan was available for mandatory training however a training needs analysis for the ward had not been undertaken. A recommendation has been made in relation to this. Inspectors noted that a number of staff highlighted concerns in relation to the aggression (both verbal and physical) directed to them from patients and the potential impact this may have on staff morale and overall care delivery. Inspectors witnessed threats and several physical attacks to staff on the ward on the day of the inspection. Patients also raised this issue with inspectors. A recommendation has been made in relation to this.	Moving towards compliance

Inspection Standards – There are procedures in place for the effective management, support, supervision and training of staff. Ward Self-Assessment	
Statement 7. – **There is an organisational structure for the ward that defines staff and management roles, responsibilities and the accountability arrangements;** **Patients and staff are aware of the organisational structure and accountability arrangements;** **Staff can describe reporting procedures;** **Senior staff can describe their role in the accountability framework for the ward, and how this works in practice.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
The ward supports the Trust's core value of accountability. Personal and professional accountability are encouraged for the provision of high quality care by competent staff in a safe environment. The ward works on seniority i.e. the most senior staff member is the Nurse In Charge. All staff are responsible and accountable for their own actions. Trained staff keep their own portfolios for NMC Practice which is open, transparent and accountable is promoted. Trained staff have responsibilities regarding mentorship and preceptorship on the unit. All staff are accountable to the patient and employer. Qualified staff are accountable to their profession bodies. Roles & responsibilities of staff are outlined through preceptorship (for Qualified Staff), inductions, employment contracts & job descriptions. The Ward Manager is overall accountable for the nursing team, to the Senior Nurse Manager and to the Service Manager and Associate Director of Nursing. Medical accountability is by the Consultant Psychiatrist who has overall responsibility for the patients care. The Ward Manager has overall responsibility / accountability to assist and support staff. Staff are encouraged to enhance their professional knowledge and competence. Reflective practice is also encouraged and post incident de-briefings take place to help improve the quality of care provided. There is a Management Structure & Trust Structure on the notice board for all staff and patients.	Moving Towards Compliance

Staff follow Trust policy and procedures in relation to reporting Induction includes reporting procedures Job descriptions are available in the ward for all staff	
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
There was an organisational structure for the ward on display in the ward office at the time of the inspection. This information has also been outlined in the patient welcome pack for the ward. The patients and staff who met with inspectors on the day of the inspection were aware of the organisational structure for the ward. Information relating to staff on duty was not available in patient areas. A recommendation has been made in relation to this.	Substantially compliant

Inspection Standards – Information for patients and carers Ward Self-Assessment	
Statement 8. – **Patients and their family/carers have access to information in relation to their rights;** **There is a defined complaints procedure in place in a format appropriate to the needs of patients and their carers;** **The ward maintains appropriate records of complaints, concerns, suggestions and compliments.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
The vulnerable adult policy is available on the ward. Easy read leaflets are available for patients in the welcome pack and on the ward. Leaflets include " Your right to confidentiality", "You, Muckamore Abbey and the Law", "If you have complaint, lets talk about it', 'Keep me safe, treat me with respect' Leaflets are also available for families With regards to detained patients - their statement of rights is provided and read and explained to them if required, there is an easy read booklet available to help explain The Trust's Complaints Procedure is adhered to. A member of the nursing team will always be available to support patients, carers and advocates following an incident to offer reassurance in order to encourage therapeutic relationships between all. The ward promotes the Trust value of openness and trust where there are clear processes for communication between carers and staff and there is transparency, openness and trust in decision making and communication. Patients also have access to advocates, the Patients Council, Patient Forum groups on the ward and the TILLI group, where concerns or complaints can be raised, suggestions can be made or compliments discussed. Patients are allocated a named Nurse on admission and can avail of 1:1 sessions The procedure for dealing with a complaint is displayed in the office and local resolutions forms are available for completion and filed.	Moving Towards Compliance

A copy of compliments are held in the ward. An information screen in the reception area of the ward provides information for patients, staff and families	
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
Information and guidance on how to make a compliant was on display in patient and visitor areas on the ward on the day of the inspection. This information is also included in the ward welcome pack in easy to read format. The care notes reviewed by inspectors evidenced that patients detained under the Mental Health (Northern Ireland) Order 1986 had been made aware of their rights. This information was also available to patients on the ward in an easy to read format. The ward welcome pack includes easy to read information for patients including 'You, Muckamore Abbey and the Law'; 'Your Right to Confidentiality'; Keep me safe, treat me with respect'; and 'If you have a compliant, let's talk about it'. A policy for dealing with complaints is in place for staff to follow which includes a 'local resolution complaints policy'. Although some concerns raised by patients have been addressed, no complaints have been recorded for this facility for a number of years. A recommendation has been made in relation to this. Complements and complaints are discussed at monthly unit meetings with the operational manager for the ward so that learning can be shared with other facilities on the hospital site.	Substantially compliant

Inspection Standards – The organisation has a clear policy on the documentation and management of records, confidentiality and sharing of information. **Ward Self-Assessment**	
Statement 9 – **Care plans are written in an individualised and person-centred manner that is consistent with professional and legislative requirements.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
All patients have a person centred care plan which adheres to professional and legislative requirements. Care plans are audited through the EQC audit annually. Each care plan is reviewed as required and at a minimum of 6 monthly. Care plans are signed and dated appropriately. All patients have a named nurse responsible for their care plan. All staff adhere to the Records Management Policy. All qualified staff adhere to the NMC code of conduct which includes record keeping. Staff report/record in the care plan on a daily basis. All staff are aware of the policy relating to confidentiality and adhere to same. Staff are aware of the Data Protection Act (1998) and the Access to Health Records (NI) Order (1993). All care is discussed in weekly MDT meetings, Careplans are stored in a secure fireproof filing cabinet.	Substantially Compliant
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
Inspectors reviewed care documentation relating to four patients on the day of the inspection. Pre-printed care plans are used on the ward. Inspectors found that planned interventions contained within care documentation reviewed was not sufficiently personalised to the patient, lacked detail and in some cases did not contain interventions or actions to address problems identified in the nursing assessment. The rationale for some interventions was not included in the care documentation reviewed. Despite weekly care review at the multidisciplinary meetings, many of the care plan interventions were recorded as being reviewed six monthly.	Not compliant

A recommendation has been made in relation to this.	

Inspection Standards – The organisation has a clear policy on the documentation and management of records, confidentiality and sharing of information. **Ward Self-Assessment**	
Statement 10. – **Staff report accidents, incidents and Serious Adverse Incidents in accordance with policies and procedures and regional guidance.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
Staff adhere to Trust Policy in relation to reporting accidents, incidents and serious adverse incidents. Incidents are reported through the incident reporting system - Datix. All incidents are recorded in the patients care plan and discussed with the ward team. Serious incidents are discussed on a weekly basis at the MDT meeting. Adverse Incident Reporting training is available. SAI's are reported to Senior Hospital Management and Hospital Consultant immediately & RQIA is notified. Incident reports are available on request. Incident reports are scrutinized by the hospital management team and through Risk & Governance. Monthly incident reports are shared with all staff	Moving Towards Compliance
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
Inspectors were shown the computerised reporting system (Datix) for recording and reporting accident, incidents and near misses. Referral to other members of the multi-disciplinary team had been made were necessary, including the Vulnerable Adults Safeguarding team. However, the ward sister stated that she did not receive information from the governance department in relation to analysis of accidents/incidents on the ward. A recommendation has been made in relation to this.	Substantially compliant

Appendix 1 – Quality Improvement Plan

Quality Improvement Plan

Announced Inspection

Cranfield Women's Ward, Muckamore Abbey Hospital

9 July 2013

The issue(s) identified during this inspection are detailed in the inspection report and the Quality Improvement Plan.

The details of the Quality Improvement Plan were discussed with the Ward Sister, Operations Manager, Consultant Psychiatrist, Senior Manager and Clinical Director on the day of the inspection visit. Please refer to Appendix 3 for specific reference documents. The timescales for completion commence from the date of the inspection.

1. Recommendations restated from previous inspection

No.	Recommendation	Number of times stated	Details of action to be taken by ward/trust	Timescale
1	It is recommended that patients' involvement in the assessment and care planning process is consistently documented.	2	Patients involvement is evidenced in the assessment, planning, intervention and evaluation stages of care planning - if the patient is unable to be involved or declines involvement, this is documented	**Immediate and on-going**

2. Recommendations made following inspection of safeguarding vulnerable adults and children – human rights theme of protection

No.	Recommendations	Document Number	Reference	Details of action to be taken by ward/trust	Timescale
	The organisation has appropriately trained staff and robust procedures to support and meet the needs of patients				
1	It is recommended that the ward sister ensures that policies, procedures, guidance and training in safeguarding vulnerable adults is included and recorded in the induction programme for new staff.	18	Section 3	The induction book was reviewed in August 2013. Policies, procedures, guidance and training in safeguarding vulnerable adults for all new staff has been added	**1 November 2013**
2	It is recommended that the trust ensures that details of protection plans developed in response to adult safeguarding referrals are documented clearly on the safeguarding documentation.	18	Section 5	A flowchart was devised in July 2013 and shared with all wards. The flowchart demonstrates the link between the Adult safeguarding procedure process and the care plan. Following an adult safeguarding incident, a	**Immediate and on-going**

No.	Recommendations	Document Number	Reference	Details of action to be taken by ward/trust	Timescale
				protection plan is written or, if already in place, reviewed in the care plan and the details of this protection plan is recorded on the Adult Safeguarding form. When the Adult Safeguarding form is returned to the ward, if necessary the protection plan in the care plan is further reviewed and updated	
3	It is recommended that the trust ensures that a formal mechanism to alert the safeguarding officers to multiple referrals due to the same alleged perpetrator is developed, implemented and included in the Trust Vulnerable Adult Safeguarding Procedures.	18	Section 1	Multiple referrals due to the same alleged perpetrator are alerted through post incident briefings and discussed at the MDT meeting where action is agreed. If necessary a further MDT meeting is arranged to address and agree options for the perpetrator.	**1 October 2013**

No.	Recommendations	Document Number	Reference	Details of action to be taken by ward/trust	Timescale
	Assessment of need and risk				
4	It is recommended that the ward sister ensures that risk assessments and care plans are discussed with the patient and their carer. This should be evidenced within the care documentation.	12	Statements 3;8;11	Patients involvement is evidenced in the assessment, planning, intervention and evaluation stages of care planning - Risk assessments are also discussed with the patient and the relative / NOK, if applicable and signed to reflect involvement. If the patient is unable to be involved or declines involvement, this is documented.	**Immediate and on-going**
5	It is recommended that the ward sister ensures that the template for recording the multi-disciplinary team meetings includes domains to record patient/relative views/involvement, names of those present, agreed actions and outcomes including responsibility for completion, agreed timescales for completion, and review of risks.	12	Statements 3;8	A revised format for recording MDT meetings was developed in July 2013. This has been piloted in the hospital and is in use in all wards. This includes sections to record patient/relative views/involvement, names of	**1 November 2013**

No.	Recommendations	Document Number	Reference	Details of action to be taken by ward/trust	Timescale
				those present, agreed actions and outcomes including responsibility for completion, agreed timescales for completion.	
6	It is recommended that the ward sister introduces a system of auditing of records and record keeping to ensure defined processes are followed by relevant staff.	17	Section 5.3	A new care plan has been developed. It is anticipated this will be in use by the end of October 2013. Guidelines for completion have been developed as part of the review; these guidelines will be the basis of the EQC audit (which is also being reviewed as part of the project). The audit will take place once a year in all wards, but will be available for ward staff to complete internal audits	**1 November 2013**
	Awareness and application of safeguarding procedures				

No.	Recommendations	Document Number	Reference	Details of action to be taken by ward/trust	Timescale
7	It is recommended that the trust ensures that staff within Cranfield Women's receive awareness training on their role in relation to Deprivation of Liberty Safeguards (DOLS) – Interim Guidance, as outlined by the DHSSPSNI in October 2010	6		Ward Sisters and Charge Nurses have received awareness training in May 2013 on their role in relation to Deprivation of Liberty Safeguards (DOLS) – Interim Guidance, as outlined by the DHSSPSNI in October 2010. The training slides have been forwarded to the Ward Sisters and Charge Nurses to share with other ward staff.	**1 October 2013**
8	It is recommended that the ward sister ensures that the Deprivation of Liberty Safeguards (DOLS) – Interim Guidance, as outlined by the DHSSPSNI in October 2010, is implemented within Cranfield Women's ward.	6		Guidance, as outlined by the DHSSPSNI in October 2010, will be implemented within Cranfield Women's ward	**1 October 2013**
9	It is recommended that the ward sister ensures that that care plans in relation to actual or perceived deprivation of liberty are reviewed to ensure that an	6		Patients care plans are currently being reviewed in relation to actual or perceived deprivation of	**1 October 2013**

No.	Recommendations	Document Number	Reference	Details of action to be taken by ward/trust	Timescale
	explanation of deprivation of liberty is included and relevant to the plan of care.			liberty. An explanation of deprivation of liberty is included	
10	It is recommended that the trust ensures that the 'restriction checklist' currently in use on the ward is reviewed to ensure that the implementation of this tool is appropriate to the care environment.	6		If restrictive practice is required - this is individually assessed for each patient and a plan of care appropriate to the needs of the patient developed, through the MDT. The 'restriction checklist' is not appropriate as it is not person centred.	**1 October 2013**
	Provision and access to therapeutic activity				
11	It is recommended that the ward sister ensures that a timetable of ward based activities is developed, implemented and shared with patients.	12	Standard 13	An activity chart of activities was developed in August 2013. This is available for the patients.	**1 November 2013**
12	It is recommended that the trust ensures that a needs/capacity analysis is	17	Section 4.3	All patients in the ward have access to these services on a	**1 November 2013**

No.	Recommendations	Document Number	Reference	Details of action to be taken by ward/trust	Timescale
	undertaken to establish need for and availability of clinical therapeutic inputs to include psychiatric, psychological, behavioural, social work and occupational therapy specialties.			referral basis	
	The organisation operates effective procedures for managing patients' finances and property				
13	It is recommended that the trust ensures that a new policy for mobile phone use is developed and implemented.	16		The SNM is exploring options to develop a policy for the use of mobile phones. Guidelines are available	**1 November 2013**
	There are procedures in place for the effective management, support, supervision and training of staff.				
14	It is recommended that the trust ensures that the supervision needs for all staff working on the ward is examined and that	17	Section 4.3	A timetable of supervision for all staff working on the ward was developed in	**1 October 2013**

No.	Recommendations	Document Number	Reference	Details of action to be taken by ward/trust	Timescale
	a timetable of supervision for all staff working on the ward is developed and implemented so that staff receive regular supervision appropriate to their needs and role.			August 2013.	
15	It is recommended that the trust put a system in place so that the ward sister/nurse in charge can ensure that bank staff have the appropriate training skills and knowledge to work on the ward.	18	Section 2	The Bank office is responsible for ensuring bank staff receive appropriate training skills and knowledge to work on the ward. The SNM for the ward will link with the bank office staff to develop a system to ensure that bank staff do have the appropriate training skills and knowledge to work on the ward	**1 November 2013**
16	It is recommended that the ward manager ensures that a training needs analysis is undertaken and that a training plan is developed from the findings of this analysis.	17	Section 4.3	The ward manager will ensure that all staff have an annual appraisal which includes a personal development plan. The ward	**1 November 2013**

No.	Recommendations	Document Number	Reference	Details of action to be taken by ward/trust	Timescale
				manager will also give consideration to incidents, complaints and any other service needs. This information will be used to complete a learning needs assessment proforma which will be forwarded to their line manager and the NDL for consideration in the education commissioning process. There is a mandatory training matrix for learning disability which was reviewed and updated in September 2012, this is currently under review again. This was developed from the Trust mandatory training policy. There is a training record which the ward manager will use to highlight when staff are required to	

No.	Recommendations	Document Number	Reference	Details of action to be taken by ward/trust	Timescale
				attend for mandatory training.	
17	It is recommended that to promote optimum levels of care and treatment, the trust put a mechanism in place to ensure that staff at all levels working with patient's on Cranfield Women's Ward are fully supported in their role.	20	Standard 8	Availability of support mechanisms have been discussed at a staff meeting - these include Occupational Health, Staff Supervision, Psychology Support and Staffcare	**Immediate and on-going**
	There is an appropriate organisational structure for the ward that defines staff and management roles, responsibilities and the accountability arrangements				
18	It is recommended that the ward sister ensures that information relating to staff on duty is displayed in patient areas.	12		This information is displayed in patient areas	**1 November 2013**
	Information for patients and carers				

No.	Recommendations	Document Number	Reference	Details of action to be taken by ward/trust	Timescale
19	It is recommended that the trust ensures that the local complaints resolution form is completed as necessary.	17	Section 8.1	The trust complaints process is available in the office and the local complaints resolution form is completed as necessary.	**1 November 2013**
	The organisation has a clear policy on the documentation and management of records, confidentiality and sharing of information.				
20	It is recommended that the trust ensures that all care documentation is accurate, current, personalised and in keeping with relevant published professional guidance documents including NMC Record keeping guidance and DHSSPSNI 2010 Deprivation of Liberty Safeguards (DOLS) – Interim Guidance.	17	Section 5.3	A new care plan has been developed. It is anticipated this will be in use by the end of October 2013. Guidelines for completion have been developed as part of the review. The review of care plans goes towards ensuring care documentation is accurate, current, personalised and in keeping with relevant published professional guidance documents including NMC	**1 November 2013**

No.	Recommendations	Document Number	Reference	Details of action to be taken by ward/trust	Timescale
				Record keeping guidance and DHSSPSNI 2010 Deprivation of Liberty Safeguards (DOLS) – Interim Guidance. SECTION 21 LOCKED FOR EDITING THEREFORE THE ACTION IS DETAILED HERE:- A monthly report in relation to incidents is produced for the hospital. This report is a standing agenda item at staff meetings. If further breakdown of information is required this can be requested and obtained prior to the meeting.	
	The organisation has a clear policy for the reporting of accidents, incidents				

No.	Recommendations	Document Number	Reference	Details of action to be taken by ward/trust	Timescale
	and serious adverse incidents				
21	It is recommended that the trust ensures that a system to provide the ward sister with information in relation to review and outcomes of accidents, incidents and near misses that may influence ward practices is implemented.	18	Section 5		**1 November 2013**

The Quality Improvement Plan is to be signed by the Chief Executive and returned to:

Mental Health and Learning Disability Team
The Regulation and Quality Improvement Authority
9th Floor, Riverside Tower
5 Lanyon Place
Belfast
BT1 3BT

Signed: _____

Name: colm donaghy

Date: 18 sept 2013

FOR OFFICE USE ONLY:

QIP viewed by inspector on:

Date: _____

Signed: _____

Name: _____

Appendix 3 – MHLD Reference Documents

MHLD Document Number	Legislation Title
1	AIMS -Older People(2009)
2	AIMS-Working Age Adults(2009)
3	AIMS-Learning Disabilities(2010)
4	Circular HSS(F)57/2009 – Residents' Monies
5	Complaints in HSC: Resolution & Learning (2009)
6	DHSSPS Interim Guidance - Deprivation of Liberty(2010)
7	DHSSPS Guidance - Restraint and Seclusion(2005)
8	Human Rights Act(1998)
9	Improving Dementia Services Reg Strategy(2011)
10	Learning Disability Service Framework(2012)
11	Mental Health(NI)Order(1986)
12	NICE Quality Standard 14-User experience(2011)
13	NICE Clinical Guideline 136 -User experience(2011)
14	OPCAT(2002)
15	Procedure for Reporting & Follow Up of SAIs(2010)
16	Promoting Quality Care(2009)
17	Quality Standards for HSC(2006)
18	Safeguarding VAs-Shared Responsibility(2010)

MHLD Document Number	Legislation Title
19	Safeguarding VAs-Protection Policy & Guidance(2006)
20	Service Framework for Mental Health & Well Being (2011)
21	UN Convention-Person with Disabilities(2006)
22	UN Convention-Rights of the Child(1989)
23	UTEC Guidance(2007)