The Regulation and Quality Improvement Authority

RQIA

Mental Health and Learning Disability

Unannounced Inspection

Greenan Ward

Muckamore Abbey Hospital

Belfast Health & Social Care Trust

23 & 24 October 2014

npm national preventive mechanism

informing and improving health and social care

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Contents

1.0 General Information

Ward Name	Greenan Ward
Trust	Belfast Health & Social Care Trust
Hospital Address	Muckamore Abbey Hospital 1 Abbey Road Muckamore BT41 4SH
Ward Telephone number	028 94662305
Ward Manager	Mary Bogue
Email address	mary.bogue@belfasttrust.hscni.net
Person in charge on day of inspection	Tanya Glass
Category of Care	Continuing care Learning Disability
Date of last inspection and inspection type	PEI inspection 6 May 2014
Name of inspector	Wendy McGregor

2.0 Ward profile

Greenan Ward is situated on the Muckamore Abbey Hospital site. The purpose of the ward is to provide continuing care and support to adults with a learning disability who may have complex health care needs.

On the day of the inspection there were no patients who were detained under the Mental Health (Northern Ireland) Order 1986.

Patients on Greenan ward were in the process of resettlement to accommodation in the community. The inspector was informed by the deputy ward sister that resettlement meetings are held monthly.

Patients within Greenan ward received input from a multidisciplinary team which incorporated psychiatry; nursing; occupational therapy, and behavioural support. Patients could access dietetics, podiatry and speech and language therapy by referral. Patients on the ward accessed five sessions of day care per week. A patient advocacy service was also available.

On the days of the inspection, the inspector noted the ward was welcoming. The ward was well lit, well maintained, clean and fresh smelling. The ward

was noted to be spacious, which gave patients, with restricted mobility, independence to transfer safely and freely around the ward. There were separate day spaces and dining areas for male and female patients and an additional quiet day space for patients who wished to access it. It was good to note that there were a number of photographs displayed on the ward of patients participating in activities.

There were separate sleeping areas for male and female patients. The inspector noted the position of large pieces of furniture between beds to promote and maintain patient privacy and dignity. Screens were also available in the shared sleeping areas. Patient sleeping areas were individualised with patients' personal items. Single bedrooms were available for some patients. Bathrooms were clean and clutter free. Entry to the ward was via a key pad system, exit from the ward was not locked and patients could leave at any time. Patients had access to the garden.

There was a separate room for patients to meet with their visitors in private. The deputy ward sister stated this was optional as some relatives liked to visit in the patient communal areas if appropriate.

Signage both outside and inside the ward was good and supported patients with orientation around the ward.

On the days of the inspection occupancy levels were nine. There were eight patients on the ward and one patient was on trial resettlement leave.

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 Greenan Ward was undertaken on 23 and 24 October 2014.

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

The recommendations made following the last announced inspection on 24 & 25 January 2012 were evaluated. The inspector was pleased to note that all 25 of recommendations had been fully met and compliance had been achieved in the following areas:

- Advocacy services had been developed and included an in-reach service to patients on a consistent and proactive basis and the roles and responsibilities of the service was defined.
- The ward had developed a 'welcome pack' that was accessible to all patients. This included information about patient's rights on the ward.
- Patients who had specific communication needs had these assessed and an appropriate care plan was developed.
- Support from administrative staff had been reviewed and increased. This promoted compliance with records management and filing guidelines.
- Patients had an individualised programme of activities and those patients that did not attend external day time activities had the opportunity to engage in meaningful ward based activities which reflected their personal preferences.
- The ward induction programme included the vulnerable adults procedure, the whistle blowing policy, and handling patient's money guidance.
- All staff had received up to date supervision.
- Alternate efficient options for training staff were offered on site.
- All unexplained injuries were considered in relation to vulnerable adults procedures.
- The threshold for vulnerable adults was discussed, agreed and was monitored.
- All staff had access to the appraisal of policy and guidance.
- The matter of using the risk assessments on the ward was resolved and agreed. Documentation for risk management was signed off by relevant staff.
- The overview reports from governance were resumed and included an analysis of learning.
- A code of behaviour was developed for the ward.
- User friendly information in relation to rights to access information was developed and shared with patients and their relatives.
- The "best interest proforma" was used to facilitate debits from patients accounts when they lack capacity. Consultation of relatives and/or advocate was clearly referenced.

- The practice of using a sum of patients money to collectively purchase 'treats' for all patients has stopped and purchases for patients were individually stored and patients received items that they have purchased.
- The system for tracking patients' clothes/personal items was monitored robustly.
- Children's visiting arrangements were included in the welcome pack and displayed on the ward and an appropriate area was designated that provided privacy and safe guards.
- The additional recommendation in relation to;
    - Staffing levels
    - Access of ward
    - Support for laundry duties and administrative activities
    - Environment
    - MDT Template

  were fully actioned.
- An audit was undertaken of the workload on the ward, and included patient therapeutic time.
- Patients' outings off the ward were reviewed.
- The provision of laundry and clerical support was reviewed.
- The needs of the patients' population was assessed and the use of the space was prioritised to enhance privacy for patients. There was a private visiting area on the ward.
- A multi-disciplinary template had been agreed and was used to records the minutes of the multi-disciplinary reviews

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

The recommendation made following the patient experience interview inspection on 20 November 2013 was evaluated. The inspector was pleased to note that the recommendation had been fully met and compliance had been achieved in the following area:

- All patients were informed of the advocacy services in a format suitable to their needs.

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

The recommendations made following the finance inspection on 31 December 2013 were evaluated. The inspector was pleased to note that both recommendations had been fully met and compliance had been achieved in the following areas:

- A record of staff who access the key to the Bisley drawer and the reason for access was maintained
- A weekly reconciliation of patients' money against the cash ledger was undertaken and appropriate records were maintained

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

A serious adverse incident had occurred on this ward on 24 June 2014. The incident was in relation to a safeguarding vulnerable adult referral and investigation. The inspector noted policy and procedure in relation to safeguarding vulnerable adults had been followed. The inspector was informed by the designated officer that the investigation is ongoing, and appropriate measures had been undertaken.

Details of the above findings are included in Appendix 1.

5.0 Inspection Summary

Since the last inspection it was good to note that RQIA recommendations made in relation to other wards on the Muckamore Abbey Hospital site had been shared and implemented on Greenan ward. The inspector was pleased to note that all recommendations made from previous inspections had been fully met. The inspector was pleased to observe that staff treated patients with dignity and respect. There was evidence of a good level of patient outings and activities on the ward. There was also good evidence of patient and family involvement in relation to decisions about patient care.

The inspector observed therapeutic engagement between staff and a patient receiving palliative care. Staff were sensitive to the patients' needs and were observed engaging compassionately with the patient and ensured the patient was comfortable.

It was good to note that a staff nurse on the ward and the Greenan nursing team have been nominated for an award for their care of a patient receiving palliative care.

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.

On the days of the inspection, information in relation to Capacity to Consent and Human Rights was available for staff and patients on the ward. Patient and / or relative involvement in all aspects of care was evident in the care documentation. The inspector spoke to one relative, who stated they had been consulted in any decision making processes. Staff confirmed their knowledge on Capacity to Consent and informed the inspector of the steps they took to ensure the patient consented to care and treatment.
There was a record in one set of care documentation where a patient had bloods taken however it was not documented if the patient had consented to this. Staff interviewed stated that the patient had consented and detailed how they would have known if patient had not.
Care plans had been completed for particular physical health checks, however there was no reference to obtaining consent before the health check, or the

action to follow if a patient did not consent, and there was no reference made to use the best interest check list or decision making tool. However, staff had knowledge on when to use the best interest check list and decision making record. Recommendations have been made in relation to this.

Patients' capacity to manage and control their finances was assessed and a financial control form was completed and signed by the consultant psychiatrist, with evidence of family involvement. Capacity and Consent and Human Rights awareness are included in the staff ward induction programme. Not all staff had attended training on Capacity and Consent, Human Rights and Deprivation of Liberty. Recommendations have been made in relation to this.

There was evidence that staff had knowledge of patients Human Rights article 8 rights to respect for private and family life, and this was also documented in the patients care documentation.

Each patient had an individualised assessment of needs, comprehensive risk screening tool and person centred care plan completed. Each care plan met the assessed needs of the patient. Risk assessments and care plans were reviewed and updated 6 monthly or earlier if required by the multidisciplinary team. However the multi-disciplinary template was not consistently completed by all staff as there were sections left blank with and no reason recorded for this and signatures of the patients' family were not consistently completed. A recommendation has been made in relation to this.

There was consistent documented evidence in the patients' daily progress of patient and family involvement. Where patients were not involved, there was a clear rationale recorded in relation to the patients limited level of understanding.

Comprehensive risk screening tools were completed in accordance with Promoting Quality Care Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services May 2010.and were signed by the patients' relative.

Each patient had an assessment of their communication needs and a communication passport completed. Staff demonstrated their knowledge of the patients communication needs and were familiar with patients' likes, dislikes and choices. The inspector noted in one patients' daily progress notes that the patient had been refusing their Epilepsy medication. It was documented that this had been discussed with the multi-disciplinary team and different options had been tried to encourage concordance, e.g. change of time of administration. However this information was not collated in a care plan / pathway and there was no agreed plan of what action to take if the patient continually refuses. A recommendation has been made in relation to this.
The inspector spoke to one relative during the inspection, the relative stated that they had been kept informed of their family members' assessments, care plans, and risk assessment and that the care documentation had also been

sent to them for review and comment. The relative stated the staff frequently contacted them by phone and informed them of any changes in their family members' health.

On the first day of the inspection seven of the eight patients went out for a pre-Christmas dinner to a restaurant. This was planned early due to the number of patients planned for discharge before Christmas and the staff wanted to have the opportunity to mark the occasion with the patients and to provide the opportunity for the patients to mark the occasion with their friends.

Patients had individualised assessments for therapeutic and recreational activity plans. Patients attend day care in "Moyola". One patient was receiving palliative, and remained on the ward, the inspector observed that this patient had beauty treatment during the inspection and staff were actively and therapeutically engaging with the patient. The patient also received input from the hospital aroma therapist. Information was displayed in relation to activities offered on the ward. Occupational Therapy (OT) assessments and reports were included in the patients care documentation reviewed, and OT recommendations were included in the care plans. Patients' likes, dislikes and choices were included in the care documentation reviewed. Patient participation or otherwise was recorded in the daily progress notes and included detail of patients' reaction to particular activities. The number of patient outings was recorded as 42 in August and 43 in September.

Easy read information in relation to; the patients charter, how to make a complaint, how to access independent advocacy services was displayed in the patients communal areas. A ward information pack was available for patients and relatives. Staff were familiar with how to access and effectively utilise advocacy services. Advocacy involvement was documented in the patients care documentation. One relative wrote on the relative/carer questionnaire that they had met with the advocate on several occasions because they were present at the MDT meetings.

Information in relation to the Human Rights Act was available for staff on the ward. Staff interviewed demonstrated their awareness of patients Human Rights. Consideration was given to patients Human Rights article 5 rights to liberty and article 8 respect to private and family life. The four staff interviewed demonstrated their awareness of patients Human Rights.

Exit from the ward was not locked and patients had open access throughout the ward including access to the garden area.

Each patient had an individualised restrictive practice and Deprivation of Liberty care plan completed. Each restriction was recorded, and the rationale identified the risk as the need for the restriction. Care plans demonstrated that the restrictions were proportionate to the risk and the least restrictive. Care plans were signed by patients' relatives. The use of the restrictive practices was reviewed regularly.

Consideration was given and documented in relation to Human Rights; Article 3 right to be free from torture, inhuman or degrading treatment or punishment,

Article 5 rights to liberty and security of person and Article 8 respect to private and family life.

Relatives indicated they knew what the restrictions were on the ward.

Staff demonstrated their knowledge and understanding of the trust policy and procedure on the use of restrictive practices and were familiar with the Deprivation Of Liberty Safeguards – Interim Guidance DHSSPS 2010.

A weekly template was completed with; details of incidents/accidents that had occurred, names of the persons involved, action / learning from the incidents and previous related incidents and sent to the hospital manager. The learning from incidents is shared at the team meetings.

Greenan ward is categorised as a resettlement ward. Seven of the eight patients have been assessed as ready for resettlement into community. One patient was receiving palliative care and the inspector was informed there were no plans in place for this patient. Resettlement meetings occurred on a monthly basis. Discharge care plans were individualised and detailed. Staff accompanied the patients during introductions to their new homes, and documented how patients reacted to their new environment and the guidance they gave to staff on how to care for the patient. Staff from the new facilities visited patients on the ward to get to know them. Relatives indicated they were involved their relatives' person centred discharge plan.

Details of the above findings are included in Appendix 2.

On this occasion Greenan ward 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	**4**
Relatives	**1 (by telephone)**
Other Ward Professionals	**1**
Advocates	**0**

Patients

The inspector spoke to one patient. The patient stated they were happy on the ward and enjoyed their “pre-Christmas” dinner at a restaurant that day and we looking forward to the Halloween party planned for the weekend.

Relatives/Carers

The inspector spoke to one relative on the phone. The relative stated they were very pleased with their family members care. The relative stated staff contacted them frequently and discussed aspects of their relatives care and decisions in relation to resettlement. The relative said staff were very caring.

Ward Staff

The inspector met with nursing staff on the ward. The staff stated they were well supported and ward management were approachable. The nursing staff stated they had known the patients for a long time and although they were happy to see the patients moving out into the community they were also sad to see the patients leave due to the longstanding history and the relationship they had established with the patients.

Other Ward Professionals

The inspector met with the hospital Safeguarding Vulnerable Adults Designated Officer (DO). The DO stated that staff were familiar with the Safeguarding Vulnerable Adult policy and procedure and were making appropriate referrals in accordance with policy and procedure.

Advocates

The inspection was unannounced; there were no advocates available on the days of the inspection.
Questionnaires were issued to staff, relatives/carers and other ward professionals in advance of the inspection. The responses from the questionnaires were used to inform the inspection process, and are included in inspection findings.

Questionnaires issued to	Number issued	Number returned
Ward Staff	20	14
Other Ward Professionals	5	2
Relatives/carers	9	5

Ward Staff

Questionnaires were returned by nursing staff. The majority of staff had not received training in Capacity to Consent. However most staff indicated they had received training in Human R ights and Deprivation of Liberty Safeguards. All staff stated they had received training in restrictive practices and knew what these were on the ward. The majority of staff stated they had received training in relation to supporting patients with different communication needs. All staff stated patients communication needs were recorded in their assessment and treatment plans and were aware of alternative means of communication. All staff stated the ward

had information in a format that met individual patient needs in relation to the Mental Health Order, detention processes, how to make a complaint and accessing advocacy services.

One staff stated their role was;

"To provide structure, consistency and stability on a safe, caring environment and support individuals rights and choices."

Other Ward Professionals

Questionnaires were returned from a Doctor and Occupational Therapist. Both stated they had received training in Capacity to Consent, Human Rights, Deprivation of Liberty Safeguards and restrictive practice and meeting the needs of patients who need support with communication. Both staff stated they knew what restrictive practices were used on the ward. Both staff stated all patients had their communication needs recorded in their care and treatment plan and both staff were aware of alternative means of communication.

One staff recommended; "*greater access to community facilities, outings and social inclusion could be provided. Therapeutic activities could be more individually tailored to meet level of ability."*

Staff quoted*: "very* dedicated *staff team who advocate well on behalf of patients particularly in relation to resettlement process."*

Relatives/carers

Overall relatives stated the care was good. One relative stated improvement was required and cited the reason for this. This was addressed with the deputy ward sister and designated officer and the inspector was informed that the relatives had been kept up to date with the ongoing process in relation to a vulnerable adult investigation. The trust has put safeguarding measures on place to protect the patient and other patients on the ward.

Relatives stated they had been involved in their family members care and treatment plans.

All relatives were aware of restrictive practices in relation to their family members' care.

Relatives' quoted;

"I am satisfied with the care and attention xxx receives in Greenan ward. I am frequently in touch with staff by phone. I have no problem with communications and when necessary the staff phone with regards xxx health."

"I have nothing but praise for the staff working in Greenan ward. My brother has had a difficult time with ill health recently and I have no doubt that it is the dedication, motivation and practice of the care team there that has sustained him through this difficult time. Additionally their respect and willingness to take time with his family has been a great comfort and support at a worrying time."

7.0 Additional matters examined/additional concerns noted

Complaints

The details of three complaints were sent to RQIA with the pre-inspection documentation. The inspector reviewed the record of complaints held on the ward and confirmed the details. The inspector noted that the three complaints were managed in accordance with policy and procedure.

Additional concerns

The inspector noted that one patient had been referred to psychology for a dementia assessment. The patient had received a response from psychology stating they could not accept the referral as there was no resources. A recommendation has been made in relation to this.

8.0 RQIA Compliance Scale Guidance

Guidance - Compliance statements		
Compliance statement	**Definition**	**Resulting Action in Inspection Report**
0 - Not applicable	Compliance with this criterion does not apply to this ward.	A reason must be clearly stated in the assessment contained within the inspection report
1 - Unlikely to become compliant	Compliance will not be demonstrated by the date of the inspection.	A reason must be clearly stated in the assessment contained within the inspection report
2 - Not compliant	Compliance could not be demonstrated by the date of the inspection.	In most situations this will result in a requirement or recommendation being made within the inspection report
3 - Moving towards compliance	Compliance could not be demonstrated by the date of the inspection. However, the service could demonstrate a convincing plan for full compliance by the end of the inspection year.	In most situations this will result in a recommendation being made within the inspection report

4 - Substantially Compliant	Arrangements for compliance were demonstrated during the inspection. However, appropriate systems for regular monitoring, review and revision are not yet in place.	In most situations this will result in a recommendation, or in some circumstances a recommendation, being made within the Inspection Report
5 - Compliant	Arrangements for compliance were demonstrated during the inspection. There are appropriate systems in place for regular monitoring, review and any necessary revisions to be undertaken.	In most situations this will result in an area of good practice being identified and being made within the inspection report.

Appendix 1 – Follow up on Previous Recommendations

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

Appendix 2 – Inspection Findings

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

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

APPENDIX 1

Follow-up on recommendations made following the announced inspection on 24 & 25 January 2012

No	Recommendations	No of times stated	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	It is recommended that the hospitals advocacy service is developed to include an in-reaching service to patients in Greenan Ward on a consistent and proactive basis and those roles and responsibilities are defined.	2	Easy read information in relation to both the available independent advocacy services was displayed in the patient's communal area. There was evidence in the three sets of care documentation reviewed that advocates attended the resettlement meetings. The role and responsibility of the advocate was defined as supporting the patients to resettle.	**Fully met**
2	It is recommended that the ward continue to develop the 'welcome pack' and that it is accessible to all patients. This should include information about the patient's rights on the ward. While this work has progressed it requires further development.	2	The inspector reviewed the ward welcome pack that had been developed. The welcome pack was designed in an easy read format, with the use of photos, symbols and words. The pack included information on patients' rights. The inspector was informed a copy of the welcome pack was given to patients' relatives. One relative confirmed on their questionnaire that they had received the welcome booklet.	**Fully met**
3	It is recommended that the patients who have specific communication needs have these assessed and an appropriate care plan developed.	2	The inspector reviewed care documentation in relation to three patients. All three patients had their communication needs assessed and an appropriate care plan had been developed. Each patient had a communication passport completed.	**Fully met**
4	It is recommended that the ward receive input from administrative staff to promote compliance with	2	The inspector met with administrative staff during the inspection. The ward receives administrative support 5 hours per week. The administrative staff informed the inspector their role was to support the ward with record	**Fully met**

	records management and filing guidelines. While the ward has currently three hours per week administrative support, this should be reviewed to make sure that it is adequate to meet the needs of the ward.		management and archiving, organising training for staff, stock ordering and organising staff annual leave.	
5	It is recommended that all patients have individualised programme of activities and that those patients that do not attend external day time activities have the opportunity to engage in meaningful ward based activities which reflect their personal preferences.	2	The inspector reviewed care documentation in relation to three patients. Each patient had an individualised programme of activities. This included ward based activities and did reflect the patients' personal preferences. A plan of what ward based activities was also available on the ward for group or individuals.	**Fully met**
6.	It is recommended that the ward induction programme includes the vulnerable adults procedure, the whistle blowing policy, and handling patient's money guidance.	2	The inspector reviewed the ward induction programme and noted it included the Vulnerable Adult's procedure, Whistle Blowing policy and the procedure and guidance on handling patients' money. It was noted that all bank and agency staff also received this full induction to the ward	**Fully met**
7.	It is recommended that formal supervision is provided for all staff.	2	The inspector reviewed supervision and appraisal records for all staff working on the ward. Clinical supervision for trained staff was up to date. All staff working on the ward had received up to date appraisals. The inspector noted on review of staff team meetings that all staff including bank and agency staff had the opportunity to attend team meetings.	**Fully met**
8.	It is recommended that alternate efficient options for training staff on this site are considered.	2	The inspector was informed by the deputy ward sister that the following training was available on site; Management of Actual and Potential Aggression (MAPA), Manual Handling, Fire Safety and Aids Awareness.	**Fully met**
9	It is recommended that all unexplained injuries are	2	The inspector spoke with four staff and the designated officer and was informed of the procedure followed when a patient has an unexplained injury.	**Fully met**

	considered in relation to vulnerable adults procedures.		Staff stated that all injuries were recorded on a body map, monitored and a safe guarding vulnerable adult referral completed when there was no established cause for the injury.	
10	It is recommended that the threshold for vulnerable adults is discussed, agreed and monitored.	2	The inspector spoke with the designated office and noted the policy and procedure for Safeguarding Vulnerable Adults including the regional policy was available for staff. This documentation included the threshold for vulnerable adults and had been agreed with the designated officer.	**Fully met**
11	It is recommended that staff access and appraisal of policy and guidance documentation is monitored.	2	The inspector noted the appraisal policy and guidance was available for staff. Records reviewed evidenced that all staff had received up to date appraisals.	**Fully met**
12	It is recommended that the matter of using the risk assessments on the ward is resolved and that agreed documentation for risk management is signed off by relevant staff.	2	The inspector reviewed care documentation in relation to three patients. Comprehensive risk screening tools had been completed. These had been signed by appropriate staff and a rationale provided why the patient did not require a comprehensive risk assessment. Risks were documented and managed through the patients individual care plans.	**Fully met**
13	It is recommended that the overview reports from governance are resumed and that analysis of learning is included.	2	The inspector noted overview reports had commenced September 2014. The report was completed weekly by the deputy ward sister and detailed the nature of all incidents / accidents, the names of the person involved, action and learning from the incident and any previous related incidents. These were forwarded to hospital senior management and discussed at the monthly core meetings.	**Fully met**
14	It is recommended that a code of behaviour is developed for the ward.	2	The inspector noted “The Greenan Code of Behaviour” was displayed on the ward.	**Fully met**
15	It is recommended that user friendly information in relation to rights to access information is developed and shared with patients and their relatives.	2	The inspector noted that user friendly information in relation to rights to access information was developed and available for patients in the ward welcome book and also in the patients communal area.	**Fully met**

16	It is recommended that the "best interest proforma" is used to facilitate debits from patients accounts when they lack capacity. That the consultation of relatives and/or advocate is clearly referenced.	2	The trust policy in relation to patient finances had been reviewed and updated. The inspector noted in the three sets of care documentation that patients capacity was assessed in relation to managing their finances. Patients who did not have capacity had a financial control form completed by the consultant. This form included family involvement where appropriate.	**Fully met**
17	It is recommended that the practice of using a sum of patients money to collectively purchase 'treats' for all patients is stopped and that purchases for patients are individually stored and that patients receive items that they have purchased.	2	The trust policy in relation to the management of patients' finances has been reviewed and update. The practice of using a sum of money collectively had ceased. This was evidenced during the inspection, as patients went out for the day, the inspector noted individual envelopes had been drawn up with the recorded amount and patients name on each.	**Fully met**
18	It is recommended that the system for tracking patients clothes/personal items is monitored more robustly.	2	The inspector reviewed the system for tracking patients' clothes and personal items. The inspector noted the following ; a record of the amount of money withdrawn from accounts, receipts were maintained for the purchases and checked by the nurse in charge, all purchased clothing is recorded in the marking book before sent for marking, clothing is returned and then checked by staff on return.	**Fully met**
19	It is recommended that children's visiting arrangements are included in the welcome pack and on the ward and that an appropriate area is designated which provides privacy and safe guards.	2	Children's visiting arrangements were included in the ward welcome pack. A designated area was provided for children that was private and provided safe guards.	**Fully met**
20	It is recommended that the additional recommendation in section 5 of the report • Staffing	2	On the days of the inspection there were eight patients and eight staff working on the ward. The inspector observed patients' needs were being attended to in a timely and effective manner. On the first day of the inspection all but one	**Fully met**

	• Access of ward • Support • Environment • MDT Template Are fully actioned.		patient went out for dinner during the day, this appeared to be well supported with the appropriate staffing level.. A monthly record of the number of patients' outings was recorded in the patients' communal area. It was noted that patients had 42 outings in August 2014 and 43 outings in September 2014. Staff were responsible for putting away patients clothing on return from laundry but this was not reported as a concern. Administrative support to the ward had been reviewed and the ward receives five hours per week, this was not reported as a concern. The inspector noted the ward was clean, tidy and well maintained. There was a private visiting area. Due to patients moving out, space in the patients sleeping areas has been utilised effectively to promote privacy and dignity. A Multi-disciplinary team meeting template had been agreed and was in now in use.	
21	It is recommended that an audit is undertaken of the workload on the ward, inclusive of patient therapeutic time, and a Telford assessment of need should be completed.	2	The ward has used the "Productive Ward" methodology. Details of the outcomes of this were displayed in the patient communal area, this included; patient social outings, falls, staff sick days, infection control, pressure sores, compliments and complaints. The ward was well organised and promoted an effective working environment. There were eight patients and eight staff working on the ward during the inspection.	**Fully met**
22	Inspectors were informed that patients outings off the ward are limited. Patients interviewed raised this as an issue. Inspectors asked that this is reviewed.	2	The inspector noted that a record of 42 outings in August and 43 outings in September. On the first day of the inspection all but one patient went out for the day for dinner. The inspector observed ward based activities or patients attending day care on the second day of the inspection.	**Fully met**
23	With heavy demand on nursing staff for patient care it is recommended that the provision of laundry and clerical support is reviewed.	2	Staff were responsible for putting away patients clothing on return from laundry, this was not reported as a concern. Administrative support to the ward has been reviewed and the ward receives five hours per week, this was not reported as a concern.	**Fully met**

24	It is recommended that the needs of the patients population are assessed and the use of the space is prioritised to enhance privacy for patients. Inspectors noted the lack of private visiting area on the ward.	2	On the days of the inspection there were eight patients on the ward. The inspector noted the ward was spacious and provided access to patients who required support with their mobility. The ward had a private visiting area. There was also space for patients who wished to avail of a quiet and private area.	**Fully met**
25	Inspectors referred to the duplications and omissions on the templates of MDT reviews in the notes examined. They were informed that a new template has been agreed by the MDT which is in use from January 2012 but was not in the notes examined. It was explained that the revised processes will include restrictive practices. And evidence inclusivity more fully.	2	The inspector reviewed the new multi-disciplinary team template. The template included restrictive practices.	**Fully met**

Follow-up on recommendations made following the unannounced inspection on 9 March 2012

No	Reference	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1		It is recommended that the trust reissue to staff guidance in respect of patients awake before 7am	Guidance had been issued to staff in relation to patients who are awake before 7am. The inspector reviewed care documentation in relation to one patient who experienced a disturbed sleep pattern. The inspector noted; staff had recorded the times the patients had woken and got out of bed, the attempts staff had made to encourage the patient back to bed, and how the staff had ensured the patient was comfortable when they chose to remain up ie provided patient with recliner chair and blanket. There was no record that the patient had been dressed for the day at an inappropriate time.	**Fully met**
2		It is recommended that the senior nurse that is on call for the site is informed of any patients awake and dressed prior to 7am.	The four staff spoken to were of the guidance in relation to informing senior management if patients were awake and dressed prior to 7am. In the three sets of care documentation reviewed there was no evidence to suggest this practice happened.	**Fully met**
3		It is recommended that the staffing levels for Greenan are continually reviewed to ensure that they receive an appropriate number of staff from the recruitment trawl.	On the days of the inspection there were eight patients and eight staff working the ward. The number of patients on the ward has been reduced, this has resulted in a number of staff being relocated to other wards. The deputy ward sister stated there wasn't a problem with current staffing levels.	**Fully met**
4		It is recommended that if a patient has a normal routine of waking early in the morning that this is clearly documented in the patients care plans.	In the three sets of care documentation reviewed which included one patient who had a history of disturbed sleep pattern. The inspector noted it was documented in the patients daily progress notes when the patient had woken early and a care plan had been developed.	**Fully met**

Follow-up on recommendations made following the patient experience interview inspection on 6 May 2014

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

Follow-up on recommendations made following the patient experience interview inspection on 20 November 2013

No.	Reference.	Recommendations	Number of times stated	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	6.3.2	It is recommended that the ward manager ensures that all patients are informed of the advocacy services within the ward in a format suitable to their individual needs.	1	Information in relation to the two independent advocacy services available on the ward was displayed in the patients' communal area and included the role of the service. This information was provided in an easy read format.	**Fully met**

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

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 of staff who access the key to the Bisley drawer, and the reason for access, is maintained	The inspector reviewed records in relation to the management of patient finances on the ward. There was a record maintained of staff who access the key to the Bisley drawer and the reason for this access was recorded.	**Fully met**
2	It is recommended that the ward manager ensures that regular weekly reconciliation of patients' money against the cash ledger is undertaken and appropriate records maintained	The inspector reviewed records in relation to the management of patient finances on the ward. There was a record maintained of a weekly reconciliation of patients' money against the cash ledger.	**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	BHSCT/SAI/14/102	There is an ongoing investigation in relation to a safeguarding vulnerable adult issue on the ward.	The inspector spoke to the safeguarding vulnerable adult designated officer. The designated officer updated the inspector on the current status of this investigation as ongoing. The designated officer informed the inspector that trust senior management had met with the family of the patient involved and they had been kept fully informed of the process. The inspector noted that the trust had taken appropriate safeguarding measures to ensure the protection of the patient and other patients on the ward while the investigation is ongoing.	**Fully met**

APPENDIX 2

Ward Self-Assessment	
Statement 1: Capacity & Consent • **Patients' capacity to consent to care and treatment is monitored and re-evaluated regularly throughout admission to hospital.** • **Patients are allowed adequate time and resources to optimise their understanding of the implications of their care and treatment.** • **Where a patient has been assessed as not having the capacity to make a decision there are robust arrangements in place in relation to decision making processes that are managed in accordance with DHSSPS guidance.** • **Patients' Article 8 rights to respect for private and family life & Article 14 right to be free from discrimination have been considered**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
When a patient has been assessed as not having the capacity to consent to care and treatment a record is completed in the patients assessment of needs as to how the treatment or care is and will be delivered in the patients best interests as per DHSSPS guidance Non-routine or more serious decisions are discussed with the MDT and recorded using the best interest check list and decision record, in consultation with relevant others i.e. the patient and relatives/carers and advocates, and considering the persons best interest. **The best interest checklist form can be used either if people are consulted individually or as part of a best interest case conference.**	Moving towards compliance

There are no patients in Greenan at present, who have required this process. The section 'About me' provides patient/carer/relative an opportunity to provide information about the patient, including likes/dislikes, wishes/wants and preferences - this section can be taken away for completion in the persons own time. A welcome pack is available on the ward for patients and relatives Easy read documentation available for patients and families. – consent, human rights, MHO DHSS Seeking Consent: Working with People with Learning Disabilities is available in the ward Relatives are encouraged to be actively involved through open visiting, regular phone calls and invites to MDT meetings. Patients receive feedback following MDT meetings and can request to meet with members of the MD team on other occasions if they wish. A visitors room is provided to facilitate privacy Care plans are person centred and address family involvement Privacy and dignity is addressed through the patients care plan Human Rights Act is available in the ward, all staff are aware of Article 8 and article 14, both are considered in the patients care plan Human rights awareness training is available for staff through TAS Patients' Finances and Private Property – Policy for Inpatients within Mental Health and Learning Disability Hospitals available in the ward	

Inspection Findings: FOR RQIA INSPECTORS USE Only	
Information in relation to Capacity to Consent and Human Rights was available for staff on the ward. This information was also available in easy read format for patients and their representatives. The inspector reviewed three of eight sets of care documentation and noted the following ; • staff had discussed each care plan with the patient • patients limited capacity to understand was recorded and the evidence to support this • patients reaction to information given about their care plans was also recorded • attempts to revisit the plans was recorded • a reason was recorded where patients did not sign and reflected patients level of understanding • there was evidence of family involvement in the completion of care plans • next of kin signatures were consistent throughout the documentation • relatives were invited to all monthly multi-disciplinary and resettlement meetings • relatives non-attendance was recorded • a record where family had been informed of the outcomes of the multi-disciplinary and resettlement meetings The inspector spoke to the relative of one patient on the ward who stated they had been consulted in decision making processes. One relative added the following comment to the relative/carer questionnaire; “the care team always involved the family in decision making identifying potential risks and benefits from treatment.” Four staff interviewed by the inspector confirmed their knowledge on Capacity to Consent and informed the inspector of the steps they took to ensure the patient consented to care and treatment e.g. take time to explain to the patient or, try again at a different time of the day when the patient was more settled and their level of understanding was optimum. Staff informed the inspector of the action they took if a patient showed signs that they were not consenting and stated they respected the patients’ right to refuse the care and treatment. There was a record in one set of care documentation where a patient had bloods taken however it was not documented if the patient had consented to this. Staff interviewed stated that the patient had consented and detailed how they would	Moving towards compliance

have known if patient had not, as the patient would have presented with a particular type of behaviour. This was not documented in the care documentation. The inspector noted care plans had been completed for particular physical health checks in all three sets of care documentation reviewed however there was no reference to ensuring the patient had consented before the health check, or the action to follow if a patient did not consent and there was no reference made to use the best interest check list or decision making tool. Staff interviewed had knowledge on when to use the best interest check list and decision making record. Information on patients' capacity to manage and control their finances was included in the three sets of care documentation reviewed. All three patients were assessed as not having capacity to manage their finances; a financial control form was completed and signed by the consultant psychiatrist, with documented evidence of family involvement. The policies and procedures and guidance in relation to Capacity and Consent and Human Rights were included in staff ward induction programme. Nine of fourteen staff nurses had attended up to date Consent and Capacity training. The remaining five staff had been scheduled for 19 December 2014. The deputy ward sister informed the inspector this training was not offered to nursing auxiliary staff. 21 of 32 staff working on the ward had received up to date training in Human Rights and Deprivation of Liberty. Dates for future training had not been released yet. The four staff interviewed demonstrated their knowledge of patients Human Rights article 8 rights to respect for private and family life; this was also documented in the patients care documentation.	

Ward Self-Assessment	
Statement 2: Individualised assessment and management of need and risk • **Patients and/or their representatives are involved in holistic needs assessment and in development of related individualised, person-centred care plans and risk management plans** • **Patients with communication needs have their communication needs assessed and there are appropriate arrangements in place to promote the patient's ability to meaningfully engage in the assessment of their needs, planning and agreeing care and treatment plans and in the review of their needs and services.** • **Assessment of need is a continuous process and plans are revised regularly with the involvement of the patient and/or their representative and in accordance with any changes to assessed needs.** • **Patients' Article 8 rights to respect for private and family life have been considered.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
All patients have a person centred care plan, which includes a holistic assessment and plans of care to manage identified risk. Care plans are reviewed when there is a change in risk / increase in incidents and at a minimum of 6 monthly. Patients and/or their representative are involved in this process.	Substantially compliant

Risk screening tools are completed and if deemed necessary by the MDT, patients will have a comprehensive risk assessment completed. One patient in Greenan has a CRA at present. The CRA is reviewed when there is a change in risk and at a minimum of 6 monthly Patients/carers and relatives are involved in the completion and review (when there is a change in the risk and at a minimum of 6 monthly) of care and treatment through the nursing care plan, the care plan is signed on completion and when reviewed, if patients or carers/relatives do not want to or are unable to sign – this is highlighted Patients can be referred to Speech & Language therapy when required Patients who have an assessed communication need have communication passports and/or communication place mats The Human Rights Act is available in the ward, all staff are aware of Article 8 and Article 14, both are considered in the patients care plan A guide to The Human Rights Act is available in easy read	
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	

The inspector reviewed three of eight sets of care documentation. Each patient had an individualised assessment of needs, comprehensive risk screening tool and person centred care plan completed. Each care plan met the documented assessed needs of the patient. Risk assessments and care plans were reviewed 6 monthly or earlier where there were changes to the patients' needs and care plans were updated to reflect this. There was a record that care plans were reviewed at the multi-disciplinary meetings. However the multi-disciplinary template was not consistently completed by all staff as there were sections left blank with no reason recorded for this and family involvement was not consistently completed. There was consistent documented evidence of patient and relative involvement in the patients' daily progress notes. Where patients were not involved, there was a clear rationale recorded in relation to the patients level of understanding. Comprehensive risk screening tools were completed in the three sets of care documentation, these were completed in accordance with Promoting Quality Care Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services May 2010 were signed by the patients relatives, a reason recorded if the patient did not sign and a rationale recorded of the decision not to proceed to comprehensive risk assessment. In the three sets of care documentation reviewed each patient had an assessment of their communication needs and a communication passport completed. The communication passports were individualised, detailed and provided clear guidance on how you would communicate with the patient. One relative indicated on the relative/carer questionnaire that their family members' communication needs were "more than adequately met" due to the experience and knowledge of the staff. The four staff interviewed demonstrated their knowledge of patients communication needs. Staff were familiar with individual patient needs, their likes, dislikes and choices.	Substantially compliant

Consideration to Human Rights Articles 8 rights to respect for privacy and family life was documented in the care documentation. The inspector noted in one patient's daily progress notes that a patient had been refusing their medication and this was having an effect on the patients' health. It was documented that this had been discussed with the multi-disciplinary team and different measures had been attempted to encourage concordance e.g. change of time. However this information was not collated in a care plan / pathway and there was no agreed plan of what action to take if the patient continually refuses. The inspector spoke to a relative during the inspection, the relative stated that they had been kept informed of their family members' assessments, care plans, and risk assessment and that the care documentation had also been sent to them for review and comment. The relative stated the staff frequently contacted them by phone and informed them of any changes in their family members' health.	

Ward Self-Assessment	
Statement 3: Therapeutic & recreational activity • **Patients have the opportunity to be involved in agreeing to and participating in therapeutic and recreational activity programmes relevant to their identified needs. This includes access to off the ward activities.** • **Patients' Article 8 rights to respect for private and family life have been considered.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
Therapeutic and recreational activity is individually assessed through the patients care plan All patients have individualised activity timetables Patients attend day-care on a sessional basis – off the ward. The art therapist holds individual sessions in the ward with 1 patient Patients participate in therapeutic activities on the ward, these include foot spas, cookery, art work, aromatherapy and hair and beauty A band visit the ward on a monthly basis Patients' participation and evaluation of therapeutic and recreational activities is recorded in their care plan.	Substantially compliant

A programme of available activities is on display - this includes recreational and therapeutic activities on and off the ward There is Occupational Therapy input in the ward The Human Rights Act is available in the ward, all staff are aware of and consider Article 8 through the patients care plan A guide to The Human Rights Act is available in easy read	
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
On the first day of the inspection seven of the eight patients went out for a pre-Christmas dinner. The deputy ward sister stated this was planned early due to the number of patients planned for discharge before Christmas and the staff wanted to have the opportunity to mark the occasion with the patients and to provide the opportunity for the patients to mark the occasion with their friends. The inspector reviewed three of eight sets of care documentation. There was evidence of individualised assessments for therapeutic and recreational activities. Individualised activity plans were in place. Seven of the eight patients attend day care in "Moyola". One patient is receiving palliative care , and remains on the ward, the inspector observed that this patient had some beauty treatments during the inspection and staff were actively engaging with the patient. The patient also received input from the hospital aroma therapist. Information was displayed in relation to activities offered on the ward. Occupational Therapy (OT) assessments and reports were included in the patients care documentation reviewed, and OT recommendations were included in the care plans. Patients' likes, dislikes and choices were included in the care documentation reviewed.	Compliant

Patient participation or otherwise was recorded in the daily progress notes and included detail of patients' reaction to particular activities. Information on the "Productive ward" was displayed on entry to the ward and showed the one of the outcomes as the number of patient outings this was recorded as 42 outings in August 2014 and 43 in September 2014. There was documented evidence that consideration was given to patients' Article 8 rights to respect for private and family life.	

Ward Self-Assessment

Statement 4: Information about rights • **Patients have been informed about their rights in a format suitable to their individual needs and access to the communication method of his/her choice. This includes the right to refuse care and treatment, information in relation to detention processes, information about the Mental Health Review Tribunal, referral to the Mental Health Review Tribunal, making a complaint, and access to independent advocacy services.** • **Patients' Article 5 rights to liberty and security of person, Article 8 rights to respect for private and family life and Article 14 right to be free from discrimination have been considered.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
Easy read leaflets and documents are available for patients and for use by staff / family / advocates The patients charter is available in the ward for patients and relatives - easy read An explanation of the MHO is available in the ward A guide to The Human Rights Act is available in easy read Easy read leaflets available re levels of observation Easy read booklet – 'You, Muckamore Abbey Hospital and the Law' available Easy read poster relating to advocacy is displayed	Substantially compliant

Patients' rights are addressed through the patients care plan The Human Rights Act is available in the ward, all staff are aware of and consider Articles 5, 8 and 14 through the patients care plan	
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
There were no patients detained in accordance with the Mental Health (Northern Ireland) Order 1986 on the days of the inspection. The following information was displayed in easy read format in the patient communal areas; • The patients charter • The productive ward • How to make a complaint • How to access independent advocacy services The ward information pack was available in easy read format and included the following information; • Staff available in Greenan • What to expect when you arrive • Information for visitors • Information on Independent advocacy services • Expectations in relation to care and treatment • Keeping safe • Right to confidentiality • Detention processes	Compliant

• How to make a complaint to the trust • Contact details of Mental Health Review Tribunal • Contact details of The Regulation and Quality Improvement Authority The deputy ward sister stated a copy of this pack is sent to all relatives. One relative stated on their questionnaire that they had received the pack. The inspector interviewed four staff during the inspection. Staff were familiar with how to access and effectively utilise advocacy services. Information in relation to the Human Rights Act was available for staff on the ward. The four staff interviewed demonstrated their awareness of patients Human Rights. There was evidence of advocacy involvement in the care documentation. One relative wrote on the relative/carer questionnaire that they had met with the advocate on several occasions because they were present at the MDT meetings. There was evidence in the three sets of care documentation reviewed that consideration was given to patients Human Rights article 5 rights to liberty and article 8 respect to private and family life.	

Ward Self-Assessment

Statement 5: Restriction and Deprivation of Liberty • **Patients do not experience "blanket" restrictions or deprivation of liberty.** • **Any use of restrictive practice is individually assessed with a clearly recorded rationale for the use of and level of restriction.** • **Any restrictive practice is used as a last resort, proportionate to the level of assessed risk and is the least restrictive measure required to keep patients and/or others safe.** • **Any use of restrictive practice and the need for and appropriateness of the restriction is regularly reviewed.** • **Patients' Article 3 rights to be free from torture, inhuman or degrading treatment or punishment, Article 5 rights to liberty and security of person, Article 8 rights to respect for private & family life and Article 14 right to be free from discrimination have been considered.**	**COMPLIANCE LEVEL**
Patients have a person centred care plan. Patients' needs are individually assessed and if restrictive practice is required, a clear recorded rationale for its use is documented. Use of restrictive practice is agreed by the MDT and reviewed regularly with a view to reducing the restriction – patients, relatives, carers and advocates are encouraged to partake in the review The Human Rights Act is available in the ward and considered where appropriate through the patients care plan	Substantially compliant

A guide to The Human Rights Act is available in easy read A deprivation of liberties easy read leaflet is available in the ward	
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
The inspector observed the exit from the ward was not locked and patients had open access throughout the ward including access to the garden area. The inspector reviewed care documentation in relation to three patients and noted that each patient had an individualised restrictive practice and Deprivation of Liberty care plan completed. Each restriction was recorded, and the rationale identified the risk as the need for the restriction. The care plans demonstrated that the restrictions were proportionate to the risk and the least restrictive. Care plans were signed by patients' relatives. There was evidence in the care plans that the use of the restrictive practices was reviewed regularly. There was evidence in the three sets of care documentation that consideration to Human Rights; Article 3 right to be free from torture, inhuman or degrading treatment or punishment, Article 5 rights to liberty and security of person and Article 8 respect to private and family life. Five of the five returned relative/carer questionnaires stated they knew what the restrictions were on the ward.	Compliant

The four staff interviewed by the inspector demonstrated their knowledge and understanding of the trust policy and procedure on the use of restrictive practices and were familiar with the Deprivation Of Liberty Safeguards – Interim Guidance DHSSPS 2010. The inspector reviewed the template completed weekly and sent to senior management which detailed incidents/accidents that had occurred on the ward, names of the persons involved, any action / learning from the incidents and previous related incidents. The learning from incidents is shared at the team meetings.	

Ward Self-Assessment

Statement 6: Discharge planning • **Patients and/or their representatives are involved in discharge planning at the earliest opportunity.** • **Patients are discharged home with appropriate support or to an appropriate community setting within seven days of the patient being assessed as medically fit for discharge.** • **Delayed discharges are reported to the Health and Social Care Board.** • **Patients' Article 8 rights to respect for private and family life have been considered.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
Monthly MDT resettlement meetings, for each Trust, take place in the ward - discharge planning considers the individually assessed needs of the patient - care managers attend these meetings. The care manager communicates the discharge plan to the relatives following the meeting. Relatives and advocates are invited to and attend these meetings. Delayed discharges are reported to the H&SCB The Human Rights Act is available in the ward, all staff are aware of and consider Article 8 through the patients care plan	Substantially compliant

Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
Greenan ward is categorised as a resettlement ward. Seven of the eight patients have been assessed as ready for resettlement into community. One patient was receiving palliative care and the inspector was informed there were no plans in place for this patient. The inspector reviewed care documentation in relation to three patients and noted the following; • Resettlement meetings occurred on a monthly basis, and the minutes detailed family and independent advocacy involvement and updates from the care manager from each patient's host trust. • Discharge care plans were individualised and detailed. The care plans detailed how each patient is introduced to their new home using phased in visits. • Staff accompanied the patients during the introductions to their new homes. Staff had documented how patients reacted to their new environment and the guidance they gave to staff on how to care for the patient. • Staff from the new facilities visited patients on the ward to familiarise the patients and familiarise the new staff about the patients care plans. The inspector spoke with one family member who stated they had been fully informed of the resettlement process and their views sought. The five family / carer questionnaires returned all stated they were aware and were involved their relatives person centred discharge plan.	Compliant

Ward Manager's overall assessment of the ward's compliance level against the statements assessed	COMPLIANCE LEVEL
	Substantially Compliant

Inspector's overall assessment of the ward's compliance level against the statements assessed	COMPLIANCE LEVEL
	Substantially compliant

SUPPLEMENTARY INFORMATION

For information or incidents within the last 12 months, this is interpreted as being from the date of the inspection.

Within the last 12 months, please confirm the number of Under 18 admissions to the ward and the age, gender and length of stay for each placement.							
Admission number	Age	Gender	Length of Stay (days)	Admission number	Age	Gender	Length of Stay (days)
1				8			
2				9			
3				10			
4				11			
5				12			
6				13			
7				14			

Within the last 12 months, please confirm the number of investigations undertaken on the ward and their outcomes.			
Adult Protection Investigations		**Child Protection Investigations**	
Substantiated Allegations	12	Substantiated Allegations	
Unsubstantiated Allegations	0	Unsubstantiated Allegations	
On-going Allegations	3	On-going Allegations	
Total	12	Total	

Please confirm the names of the following contacts for safeguarding children and vulnerable adults.	
The wards Nominated Manager for Safeguarding Vulnerable Adults	Michael Creaney

Quality Improvement Plan

Unannounced Inspection

Greenan Ward

Muckamore Abbey Hospital

23 & 24 October 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 Deputy Ward Sister, Deputy Ward Manager, Consultant Psychiatrist, Service Improvement and Governance Manager, Business and Service Improvement Manager, Operational manager, and, Resource Nurse, 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.

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
1	5.3.1 (f)	It is recommended that the ward manger ensures that staff assess patients consent to care and treatment and that this is recorded in the patients' care documentation.	1	Immediate and ongoing	
2	7.3 (c)	It is recommended that the ward manager develops a mechanism that ensures that information in relation to Capacity to Consent guidance is shared with all staff.	1	20 February 2015	
3	7.3 (c)	It is recommended that the ward manager ensures that all staff receive up to date training on Human Rights and Deprivation of Liberty.	1	20 February 2015	
4	5.3.1 (a)	It is recommended that the ward manager ensures a plan of care is written when a patient refuses care and treatment that could potentially have an impact on the patients' health and wellbeing. This should include the use of the best interest pathway.	1	Immediate and ongoing	
5	5.3.3 (b)	It is recommended that the ward manager ensures the multi-disciplinary template is fully completed and patient and or their	1	Immediate and ongoing	

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
		family / representative involvement is documented.			
6	6.3.1 (a)	It is recommended the trust review the provision of psychology services and ensure that all patients within Muckamore Abbey Hospital have access to this service.	1	20 February 2015	

NAME OF WARD MANAGER COMPLETING QIP	
NAME OF CHIEF EXECUTIVE / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	

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