# Unannounced Follow–up Inspection Report 12 February 2020

# Emergency Department and Neely Ward Ulster Hospital

**South Eastern Health and Social Care Trust**

**Address: Upper Newtownards Rd, Dundonald, Belfast, BT16 1RH**
**Inspectors: Thomas Hughes, Lorraine O'Donnell and Carmel Treacy**

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those, which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

## 1.0 What we look for


## 2.0 Profile of the Hospital

The Ulster Hospital is the major acute hospital in the South Eastern Health and Social Care Trust and delivers the full range of acute services for the population. The hospital includes an Emergency Department (ED), which is open 24/7 with over 90,000 people attending the department each year. The hospital also provides a comprehensive range of Diagnostic Services, a full range of Outpatient, Inpatient and Day-case Medical and Surgical Services, Cancer Care, Coronary Care, Obstetrics and Paediatric Services.

## 3.0 Service details

| **Responsible person:** | **Position:** |
|---|---|
| Mr. Seamus McGoran<br>South Eastern Health and Social Care Trust (SEHSCT) | Chief Executive Officer |

## 4.0 Inspection summary

Neely Ward and the Emergency Department of the Ulster Hospital were previously inspected on 26 September 2019. During this inspection, we identified a number of areas of noncompliance with the Regional Healthcare and Hygiene Standards and practices and The Quality Standards for Health and Social Care (2006) that required improvement.

- **Neely Ward** – hand hygiene practices, the decontamination of patient equipment and the management of sharps.

- **Emergency Department (ED)** – the decontamination of domestic cleaning equipment, the completion of mattress audits and the management of sharps.

Following consideration of our findings, we determined that an unannounced follow up inspection to the Ulster Hospital was required. We carried out a follow up inspection of both Neely ward and the Emergency Department on the 12 February 2020.

A team of inspectors from RQIAs Hospitals Programme Team undertook the inspection. This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Mental Health (Northern Ireland) Order 1986, The Quality Standards for Health and Social Care DHSSPSNI (March 2006) and The Regional Healthcare Hygiene and Cleanliness Standards.

The following areas were examined during this inspection:

- We undertook a full compliance audit of the ED and Neely ward using the Regional Healthcare and Hygiene Standards audit tool.
- We reviewed the trusts progress in addressing the areas identified for improvement detailed within the Quality Improvement Plan (QIP). These areas for improvement related to infection prevention control and the management of risks to patients with mental health needs who present at the Emergency Department.

## Infection Prevention and Control

### Neely Ward

Compliance had been achieved in all but one standard; this highlights a significant improvement from the initial inspection. An excellent standard of cleaning had been maintained in all patient bed areas and we continued to observe good practices in the management of patient linen and staff members' use of PPE. The most significant improvements had been made in respect of compliance with hand hygiene procedures and the decontamination and storage of patient equipment. The management of sharps requires additional improvement to bring this standard to compliance.

### Emergency Department

Compliance had been achieved in all but one standard, this is a significant improvement from the initial inspection. There is continued good practice in the use of personal protective equipment and hand hygiene procedures. The attention to detail in respect to cleanliness has improved, improved management of sharps, replacement of mattresses and completion of robust audits ensure compliance with standards. The progress in relation to the outstanding remedial work has been impacted on by work pressures within the department. This schedule of work needs to be completed to achieve compliance.

A review of previous Infection Prevention/Hygiene inspections of wards and departments in the Ulster Hospital has additionally highlighted a number of recurring issues, which include:

- the standard of cleaning of the general environment;
- the standard of cleaning of patient equipment;
- the handling and disposal of sharps;
- hand hygiene practices; and
- the completion of audits.

The South Eastern Health and Social Care Trust should ensure that sustained efforts are made to address recurring issues, and ensure that learning from inspections is shared with staff. Appropriate audits should be undertaken to support that standards are being maintained and where necessary improved.

Previous infection prevention and hygiene inspection reports of the Ulster Hospital are available on the RQIA website www.rqia.org.uk.

### The management of risks to patients with mental health needs who present at the Emergency Department

The inspection team continued to observe good practice in the use of a care pathway for patients who present with a mental health issue in the ED. Unfortunately, there has been no improvement in the delays experienced by patients in accessing timely adult mental health assessments within the Emergency Department. This continues to pose the risk of patients leaving the emergency department before their medical assessment is completed.

A Standard Operating Procedure in the use of CCTV has been created but a more fully developed policy is required to provide clearer direction for staff and greater consistency in its use. Since our last inspection, more ligature cutters have been obtained. There are now ten, which are located in locked cupboards throughout the department.

## 4.1 Inspection outcome

| Total number of areas for improvement | 4 |
|---|---|

There are four areas for improvement arising from this inspection. Two areas for improvement have been stated for the first time and two areas for improvement stated for a second time. These are detailed in the Quality Improvement Plan (QIP).

On the 12 February, we provided feedback to the trust management team as part of the inspection process. During this meeting, we discussed the hospital's strengths and the areas requiring improvement identified during our inspection.

We discussed the actions, which are required within the Quality Improvement Plan (QIP). The timescales for completion of these actions commence from the date of our inspection.

Enforcement action did not result from the findings of this inspection.

## 4.2 Action/enforcement taken following the most recent inspection

Other than those actions detailed in the QIP no further actions were required to be taken following the most recent inspection on 26 September 2019.

## 5.0 How we inspect

Prior to this inspection, a range of information relevant to the service was reviewed, including the following records:

- The previous inspection reports.
- QIPs returned following the previous inspections.
- Information on concerns and complaints.
- Serious Adverse Incident notifications.
- Other relevant intelligence received by RQIA.

Each area is assessed using an inspection framework. The methodology underpinning this inspection-included observation of staff practice; observation of the environment, discussions with staff and review of documentation. Records examined during the inspection include nursing records, medical records, minutes of meetings and training records.

We provided detailed feedback on our inspection findings as described in section 4.1.

## 6.0 The inspection

## 6.1 Review of areas from the last inspection dated 26 September 2019

The previous inspection of the hospital was an unannounced inspection undertaken on 26 September 2019.

## 6.2 Review of areas for improvement from the most recent inspections dated 26 September 2019.

| Areas for improvement from the last inspection on 12 February 2020 | | |
|---|---|---|
| **Action required to ensure compliance with The Quality Standards for Health and Social Care (2006)** | | **Validation of compliance** |
| **Area for Improvement 1**<br><br>**Ref**: 5.3.1(f)<br><br>**Stated:** First<br><br>**To be completed by:**<br>28 December 2019 | The standard of environmental cleaning in the equipment storage areas and linen store within **Neely Ward** and the **Emergency Department** reception and equipment storage area should be improved. Robust monitoring should be in place to provide continued assurance. | **Met** |
| | **Action taken as confirmed during the inspection**:<br><br>**Neely Ward**<br>We observed that the standard of cleaning of the equipment storage areas and the linen store had improved. Additionally these areas had been decluttered and equipment reorganised. An improved cleaning schedule had been developed and improvement had been seen in the auditing of these areas.<br><br>**ED**<br>We observed that the standard of cleaning of the reception and equipment storage area had improved. The equipment area had been decluttered and reorganised**.** An improved cleaning schedule had been developed and improvement had been seen in the auditing of these areas. | |
| **Area for Improvement 2**<br><br>**Ref**: 5.3.1(f)<br><br>**Stated:** First<br><br>**To be completed by:**<br>28 March 2020 | Improvement is required to the fabric, fixtures and fittings of **Neely Ward** and the **Emergency Department**. Remedial work should be undertaken to maximise the therapeutic environment for patients and clients. | **Partially Met** |
| | **Action taken as confirmed during the inspection**:<br><br>**Neely Ward**<br>The ward shower rooms had been completely refurbished and we were provided with plans for redecoration of the ward. | |

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| | **ED**<br>Refurbishment work had commenced however was unable to progress due to the pressures within the department. We were provided with evidence of the ongoing engagement between the Emergency Department and Estates Department planning how to progress the outstanding work. | |
| **Area for Improvement 3**<br><br>**Ref**: 5.3.1(f)<br><br>**Stated:** First<br><br>**To be completed by:**<br>28 March 2020 | A programme of decluttering and reorganisation of the **Emergency Department** storage areas should commence. Robust monitoring should be in place to provide continued assurance. | **Met** |
| | **Action taken as confirmed during the inspection**:<br><br>**ED**<br>We observed there is a regular programme of decluttering within the Emergency Department and there is robust schedule of auditing this area. | |
| **Area for Improvement 4**<br><br>**Ref**: 5.3.1(f)<br><br>**Stated:** First<br><br>**To be completed by:**<br>28 December 2019 | The standard of cleaning and decontamination of patient equipment throughout **Neely Ward** should be improved. Robust monitoring should be in place to provide continued assurance | **Met** |
| | **Action taken as confirmed during the inspection**:<br><br>**Neely Ward**<br>The standard of cleanliness of both stored and equipment in use was observed to be excellent. Staff when questioned had a good knowledge of the processes for the decontamination of equipment. A more robust cleaning schedule has been developed and observed to be used effectively. | |

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| **Area for Improvement 5**<br><br>**Ref**: 5.3.1(f)<br><br>**Stated:** First<br><br>**To be completed by:**<br>28 December 2019 | Action must be taken to improve **Neely Ward** staff adherence to trust standards on hand hygiene. | **Met** |
| | **Action taken as confirmed during the inspection**:<br><br>**Neely Ward**<br>We observed a significant improvement in hand hygiene practices amongst staff. We observed good hand washing technique used by all staff and opportunities were taken in line with the World Health Organisation (WHO) guidance "Five moments of Hand hygiene". We were provided with evidence of ongoing weekly hand hygiene audits and action plans developed for areas of non-compliance. | |
| **Area for Improvement 6**<br><br>**Ref**: 5.3.1(f)<br><br>**Stated:** First<br><br>**To be completed by:**<br>28 December 2019 | Action must be taken to improve **Emergency Department** staff adherence to trust standards on the management of sharps. Robust monitoring should be in place to provide continued assurance. | **Met** |
| | **Action taken as confirmed during the inspection**:<br><br>**ED**<br>We observed significant improvement in the adherence to trust standards on the management of sharps and there is robust monitoring in place to provide continued assurance. | |

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|---|---|---|
| **Area for improvement 7**<br><br>**Ref**: Standard 4.3 (i)<br><br>**Stated:** First<br><br>**To be completed by:**<br>28 March 2020 | A governance mechanism must be put in place for the oversight and monitoring of the assessment, care and treatment of patients with mental health needs who present at the Emergency Department.<br><br>This mechanism must take account of the management of risk and learning from any incidents. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>We observed good practice in the use of a care pathway for patients who present with a mental health issue in the Emergency Department. A protocol was also available for staff to follow in the event that a patient who presents at risk of harm leaves the department before they have been medically assessed. There was auditing of this group of patients via an interagency group and learning has come from this group's work, which has led to a change in practice at ward level. | |
| **Area for improvement 8**<br><br>**Ref**: Standard 5.3.1(c)<br><br>**Stated:** First<br><br>**To be completed by:**<br>28 March 2020 | The trust must ensure there is a policy and procedure in place for the use of CCTV in the 'secure room' in the emergency department. The trust must implement assurance mechanisms to ensure CCTV is being used in line with the policy. | **Partially Met** |
| | A Standard Operating Procedure has been developed for the use of CCTV. All staff spoken with were knowledgeable about instances when it should be used and were mindful to ensure it was switched off when not required. However staff were unsure, about who authorised the use of CCTV, how often and by whom CCTV monitoring of a patient should be reviewed and where this should be recorded. | |

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| **Area for Improvement 9**<br><br>**Ref**: Standard 5.3.1 (f)<br><br>**Stated:** First<br><br>**To be completed by:**<br>28 January 2020 | The trust must ensure that all appropriate staff are trained in the use of ligature cutting equipment. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>We were informed by staff and saw the training record for the training, which has begun in a systematic manner in the use of the ligature cutters. There are further training dates planned so that all staff will be trained. There are now ten ligature cutters located in the department. Not all staff spoken to were aware of this however we saw evidence that it had been highlighted on the daily safety brief the previous two days. | |
| **Area for Improvement 10**<br><br>**Ref**: Standard 5.3.1(f)<br><br>**Stated:** First<br><br>**To be completed by:**<br>28 March 2020 | The trust must ensure that all security staff working in the hospital attends awareness training in relation to mental health and learning disability. | **Met** |
| | **Action taken as confirmed during the inspection**:<br><br>We confirmed from training records which were provided after the inspection that there was good compliance among security staff with training related to mental health; Safe Talk:100% compliant, Towards Zero Suicide: 83% compliant, Suicide Awareness: 55%. | |
| **Area for Improvement 11**<br><br>**Ref**: Standard 5.3.3(h)<br><br>**Stated:** First<br><br>**To be completed by:**<br>28 March 2020 | The trust must ensure it has systems in place to prioritise, conduct and act upon the findings of clinical and social care audit and to disseminate learning across the organisation and the HPSS, as appropriate. | **Met** |
| | **Action taken as confirmed during the inspection**:<br><br>We observed a programme of audit with reporting and accountability mechanisms in place to respond to audit findings. We observed evidence of action plans in response to findings from audit and evidence of the dissemination of learning trough meetings, newsletters and committees. | |

## 6.2 Inspection findings

### 6.3.1 Infection prevention and control

Our inspection standards are intended to assess healthcare hygiene, general cleanliness and state of repair of the fabric of the areas, the fixtures and fitting and aspects of infection prevention and control for all hospitals and other healthcare facilities in Northern Ireland.

Our audit tool is comprised of the following sections:

- general environment;
- patient linen;
- waste and sharps;
- patient equipment;
- hygiene factors/cleaning practices; and
- hygiene practices/staff questions.

Guided by our audit tool our inspectors gather information from observations in functional areas (including direct questioning and observation of clinical practice) and, where appropriate, review of relevant documentation. The areas were also assessed against the Regional Healthcare and Cleanliness Standards.

Public areas (entrance, reception, public toilets, corridors, stairs and lift)

The entrance and the reception areas of the hospital remained clean, tidy and uncluttered. Public toilets continued to be cleaned to a good standard.

**Neely Ward**

General environment - maintenance and cleanliness

The standard of cleaning of patient bay areas, side rooms and sanitary areas throughout the ward were of an excellent standard. The ward shower rooms have been completely refurbished. Fixtures and fittings are modern in design and with wall and floor coverings finished to a high standard to allow for effective cleaning practices (Photo 1).

Photo 1: Newly refurbished shower room

The décor throughout the ward continues to show evidence of wear and tear; this was most notable to the paintwork. The ward manager however had provided evidence of planned maintenance work, which included fresh painting of the ward. The ward kitchen has undergone a deep clean and although its fixtures and fittings appear tired and worn, it is in a satisfactory state for its purpose.

During the initial inspection, we observed many items of equipment stored on units throughout the main ward thoroughfare, giving the appearance that the ward is untidy and cluttered. Additionally the ward equipment storeroom had been poorly maintained and cluttered with equipment, which was disorganised, and with no definite pre-arranged order, a number of items were stored on the floor. All equipment storage areas throughout the ward have now been reorganised and decluttered which has significantly maximised space and access for effective cleaning practices to be undertaken (Photo 2).

Photo 2: Reorganised storeroom

Patient linen

We continued to observe staff handle clean and contaminated linen safely and effectively. Previously we had observed a linen store that was untidy and with surfaces that were dusty. During this inspection, we observed a linen store that was clean, uncluttered and linen was stored tidily on shelves.

Waste and sharps

Effective arrangements for the handling and storage of waste on the ward were in place. Improvement is required in the segregation of waste as we observed a number of sharps boxes containing inappropriate pharmaceutical waste.

Equipment

We observed that the cleanliness of patient equipment has improved, which included stored and equipment in use. Improved mechanisms were in place to assure the cleanliness of equipment, which included the development of a more robust cleaning schedule and auditing regime.

Hygiene factors/cleaning practices

We observed that hand washing facilities and a range of consumables were available to enable hygiene practices to be carried out effectively. PPE was readily available and we observed that it continued to be used appropriately by staff.

Clinical hand wash sinks were used for hand hygiene purposes only. Additionally, alcohol hand sanitiser was available for use at the point of care. A range of personal protective equipment (PPE) was available and accessible to staff.

The standard of cleanliness of cleaning equipment had improved.

Hygiene practices/staff questions

We observed a significant improvement in hand hygiene practices amongst staff. We observed good hand washing technique used by all staff and opportunities were taken in line with the World Health Organisation (WHO) guidance “Five moments of Hand hygiene”

All staff when questioned had an excellent knowledge of both standard and enhanced IPC precautions, which included hand hygiene, cleaning, and decontamination of equipment. We observed good compliance with trust uniform policy.

**Emergency Department**

General environment - maintenance and cleanliness

Generally, we observed a high standard of environmental cleanliness in the Emergency Department. The department was clean, tidy and there was evidence of regular decluttering. There has been significant improvement in the standard of cleaning of high and low surfaces throughout the department and robust monitoring was in place to provide continued assurance.

The décor throughout the area continues to show evidence of damage to paintwork and flooring. However, the Clinical Manager provided evidence of the planned maintenance work and some improvement work had commenced.
The domestic store has undergone intensive cleaning and reorganisation. While the room’s fittings remain worn, it was free from clutter and personal items and equipment was stored appropriately.

Storage of equipment remains a challenge for the department, the area used to store large pieces of equipment has been reorganised to maximise space and equipment-cleaning schedules were in place and completed by staff.

As with our previous inspection, there remains the potential for unauthorised access to cleaning chemicals as they were stored in an unlocked Control of Substances Hazardous to Health (COSHH) cupboard and the door into the dirty utility room was unlocked. Cleaning and decontamination products must be stored securely when not in use.

There has been improved accessibility to information leaflets to guide visitors on infection prevention and control (IPC) practices.

Patient linen

We continued to observe that patient linen was visibly clean, and free from damage. Staff wore appropriate PPE when handling soiled/contaminated linen and placed it into the correct colour coded bag at the point of use.

Clean linen was stored exposed on an open cage in the equipment storage area; this was brought to the attention of the Clinical Manager and was replaced by a cage complete with a cover to ensure clean linen was not exposed in the department (Photo 3).

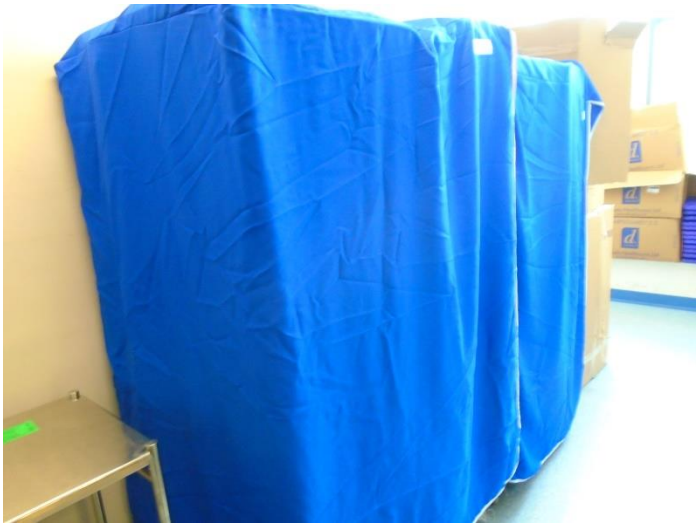

Photo 3: Covered linen trolley

Waste and sharps

We continued to observe the safe handling and transport of waste and sharps. The temporary closure of sharps container lids were clean and deployed when not in use. Sharps boxes were dated and signed. Waste was handled, segregated, stored and disposed of into the appropriate waste bin according to trust policy.

Equipment

The department has been reorganised, the storage of large items of equipment to maximise space and equipment cleaning schedules were in place and completed by staff. The standard of cleaning of stored domestic equipment had improved and robust monitoring was in place to provide continued assurance.

There was some build-up of dust and tape residue on patients' trollies and intravenous fluid stands requiring more attention to detail cleaning. The department have replaced the majority of mattresses and introduced a robust cleaning schedule and auditing regime, which includes checking the mattresses are impermeable to moisture. The Clinical Manager informed us the department were exploring the possibility of re-introducing the appointment of additional staff with responsibility for the cleanliness of trollies and mattresses. A role, which the department found previously, was very effective.

Hygiene factors/cleaning practices

We continued to observe that clinical hand washing facilities and a range of consumables were available to enable hygiene practices to be carried out effectively. Clinical hand wash sinks were used for hand hygiene purposes only. PPE was readily available and stored appropriately. We observed that it continued to be used appropriately by staff.

Information on key performance indicators including the environmental cleaning audits were clearly displayed in the ward to promote public assurance of the ward's adherence to IPC standards.

Posters and alcohol hand sanitiser was clearly visible in the reception. There was information available reinforcing the correct hand hygiene technique and general IPC precautions and correct hand hygiene technique.

Hygiene practices/staff questions

All staff when questioned had good knowledge of both the standard and enhanced IPC precautions, which included hand hygiene, cleaning, and decontamination of equipment, use of PPE and the management of sharps and waste. Hand hygiene was performed at the correct moments, at the correct location within the flow of patient care delivery. We observed good compliance with trust uniform policy.

**Level of compliance**

The table below summarises the overall compliance levels achieved in each standard/section. Scores are allocated a level of compliance using the categories described below.

**Compliant:** **85% or above**
**Partial compliance:** **76% to 84%**
**Minimal compliance:** **75% or below**

**Standard: General environment**

To comply with this standard, organisations must provide an environment, which is well maintained, visibly clean, and free from dust and debris.

| General environment standards public shared areas | 26 September 2019 | 12 February 2020 |
|---|---|---|
| Reception | 98 | 98 |
| Public toilets | 88 | 98 |
| Corridors, stairs lift | 96 | 96 |

| General environment standards wards or departments | Neely Ward 26 September 2019 | Neely Ward 12 February 2020 | Emergency Department 26 September 2019 | Emergency Department 12 February 2020 |
|---|---|---|---|---|
| Ward/department - general (communal) | 72 | 90 | 66 | 82 |
| Patient bed area | 95 | 94 | 85 | 92 |
| Bathroom/washroom | 79 | 100 | 78 | 93 |
| Toilet | 91 | 95 | 79 | 90 |
| Clinical room/treatment room | N/A | | 86 | 89 |
| Clean utility room | 90 | 96 | N/A | N/A |
| Dirty utility room | 84 | 92 | 82 | 90 |
| Domestic store | 77 | 89 | 72 | 93 |
| Kitchen | 74 | 85 | N/A | 92 |
| Equipment store | 64 | 91 | 44 | 80 |
| Isolation | 86 | 98 | 96 | N/A |
| General information | 93 | 100 | 93 | 97 |
| **Average score** | **82** | **94** | **79** | **90** |

**Standard: Patient linen**

For organisations to comply with this standard, patient linen should be clean, free of damage, handled safely and stored in a clean and tidy environment.

| Patient linen | Neely Ward 26 September 2019 | Neely Ward 12 February 2020 | Emergency Department 26 September 2019 | Emergency Department 12 February 2020 |
|---|---|---|---|---|
| Storage of clean linen | 59 | 92 | 84 | 84 |
| Storage of used linen | 100 | 100 | 93 | 89 |
| Laundry facilities | N/A | N/A | N/A | N/A |
| **Average score** | **80** | **96** | **89** | **87** |

**Standard: Waste and sharps**

To comply with this standard, organisations must ensure that waste is managed in accordance with HTM07-01and Hazardous Waste (Northern Ireland) Regulations (2005).

| Waste and sharps | Neely Ward 26 September 2019 | Neely Ward 12 February 2020 | Emergency Department 26 September 2019 | Emergency Department 12 February 2020 |
|---|---|---|---|---|
| Handling, segregation, storage, waste | 96 | 100 | 94 | 96 |
| Availability, use, storage of sharps | 72 | 87 | 83 | 87 |

**Standard: Patient equipment**

To comply with this standard, organisations must ensure that patient equipment is appropriately decontaminated.

| Patient equipment | Neely Ward 26 September 2019 | Neely Ward 12 February 2020 | Emergency Department 26 September 2019 | Emergency Department 12 February 2020 |
|---|---|---|---|---|
| Patient equipment | 82 | 98 | 87 | 89 |

**Standard: Hygiene factors/cleaning practices**

To comply with this standard, organisations must ensure that a range of fixtures, fittings and equipment is available so that hygiene practices can be carried out effectively.

| Hygiene factors | Neely Ward 26 September 2019 | Neely Ward 12 February 2020 | Emergency Department 26 September 2019 | Emergency Department 12 February 2020 |
|---|---|---|---|---|
| Availability and cleanliness of wash hand basin and consumables | 99 | 100 | 96 | 89 |
| Availability of alcohol rub | 97 | 100 | 97 | 91 |
| Availability of PPE | 100 | 100 | 94 | 100 |
| Materials and equipment for cleaning | 93 | 95 | 89 | 94 |
| **Average score** | **97** | **99** | **94** | **94** |

**Standard: Hygiene practices/staff questions**

To comply with this standard, organisations must ensure that appropriate healthcare hygiene practices are embedded into the delivery of care and related services.

| Hygiene practices | Neely Ward 26 September 2019 | Neely Ward 12 February 2020 | Emergency Department 26 September 2019 | Emergency Department 12 February 2020 |
|---|---|---|---|---|
| Effective hand hygiene procedures | 67 | 100 | 95 | 94 |
| Safe handling and disposal of sharps | 100 | 100 | 92 | 92 |
| Effective use of PPE | 92 | 100 | 94 | 89 |
| Correct use of isolation | 100 | N/A | 96 | 100 |
| Effective cleaning of ward | 76 | 100 | 90 | 95 |
| Staff uniform and work wear | 100 | 100 | 94 | 100 |
| **Average score** | **89** | **100** | **94** | **95** |

## Further inspection findings

The management of risks to patients with mental health needs who present at the Emergency Department

The inspection team observed good practice in the use of a care pathway for patients who present with a mental health issue in the Emergency Department. A protocol was also available for staff to follow in the event that a patient who presents at risk of harm leaves the department before they have been medically assessed. There was auditing of this group of patients via an interagency group and learning has come from this group's work, which has led to a change in practice. Staff reported that admission forms have now changed to include a description of what the patient was wearing, this information was often difficult to recall when reporting to the police service.

Unfortunately, there had been no change in the delays experienced in accessing timely adult mental health assessments. There continues to be an ongoing risk of patients leaving the ED their medical assessment is completed. Close supervision of patients with mental health issues are provided within an ED, which is not designed to deliver these particular care needs. Furthermore, there is no auditing of the waiting times for patients to be seen by specialist mental health staff for assessment. This information would be useful to audit for future service development.

The CCTV in Room 7 (previously referred to as the "secure room") continues on a needs based assessment use. All staff spoken with were knowledgeable about instances when it should be used and were mindful to ensure it was switched off when not required. Some staff were unsure about who authorised the use of CCTV and how often and by whom CCTV monitoring of a patient should be reviewed and where this should be recorded. Staff require clear guidelines about the use of CCTV so that they may document evidence of decision making when CCTV monitoring is used. This was recommended following our last inspection. To date, a Standard Operating Procedure has been created but a more fully developed policy is required to provide clearer direction for staff and greater consistency in its use. Inspectors noted that the monitor is located in a place which is highly visible which may impact on patient confidentiality, privacy and dignity. An area for improvement has been made.

Since our last inspection, more ligature cutters have been obtained. There are now ten in the department. They were located in locked cupboards throughout the department. Not all staff were aware of their location however, inspectors saw that it has been highlighted on the safety brief for the previous two days. Training has begun for all staff in the use of the ligature cutters. Inspectors emphasised the importance of ensuring all staff receive this training and ensuring that an interim plan is in place until full compliance with this training is achieved.

During the previous inspection, we recommended that all security staff were trained in mental health and learning disability awareness. A robust investigation of the incident, which instigated our inspection, has been completed. This investigation found that security staff acted within the confines of their training. Therefore, it is unlikely this training would have altered the actions of staff in managing the situation. The investigation report outlines that security staff have received training in Safe talk, towards Zero Suicide and suicide awareness.

Senior management advised inspectors that there are plans to invite mental health staff to further assess the needs of the security staff to establish if any further training would be beneficial to their role. We were further advised that security staff know the frequently attending patients with mental health conditions who present to the Emergency Department and have become skilled in effectively communicating with them.

| Total number of actions for improvement | 4 |
|---|---|

## 7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with the trust representatives as outlined below, as part of the inspection process. The timescales for implementation of these improvements commence from the date of this inspection.

| | |
|---|---|
| Mr D Robinson | Interim Director, Hospital Services. |
| Ms Linda Kelly | Assistant Director Safe and Effective Care |
| Mr K Quinn | Assistant Director, Women and Child Health |
| Ms J Nicholson | Interim Lead Nurse Emergency Department |
| Mr T O'Hara | Senior Manager Patient Experience |
| Ms R Devlin | Interim Clinical Manager Unscheduled Care |
| Ms C Robinson | Safe and Effective Care Manager |
| Ms M Burke | Governance Facilitator |
| Mr R Knight | Service Lead, Patient Experience |
| Ms C McClelland | Emergency Department Sister |
| Ms N Magee | Senior Infection Prevention & Control Nurse |
| Ms C McCabe | Infection Prevention & Control Nurse |
| Ms M Megran | Nursing Student |

**Apologies**

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|---|---|
| Ms N Patterson | Executive Director of Nursing |

The trust should note that if the action outlined in the QIP is not taken to comply with the standards this may lead to further action. It is the responsibility of the trust to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

## 7.1 Areas for improvement

Areas for improvement have been identified and action is required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006).

## 7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to meet the areas for improvement identified. The trust should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

| Quality Improvement Plan | |
|---|---|
| **The trust must ensure the following findings are addressed:** | |
| **Area for Improvement 1**<br><br>**Ref**: 6.3.1(f)<br><br>**Stated:** First<br><br>**To be completed by:**<br>11 March 2020 | **Neeley Ward**<br>Improvement is required in the appropriate segregation of waste disposed of into clinical sharps waste containers. Robust mechanisms should be introduced to assure staff practices. |
| | **Response by the trust detailing the actions taken:**<br>Staff have been reminded regarding appropriate segregation of waste and appropriate compliance with sharps management practice in line with Trust policies. Monitoring arrangements are in place through staff meetings, briefings, audit and in-shift checks. |
| **Area for Improvement 2**<br><br>**Ref**: 6.3.1(f)<br><br>**Stated:** First<br><br>**To be completed by:**<br>11 March 2020 | The **Emergency Department** must ensure all COSHH products are stored appropriately to prevent unauthorised access. |
| | **Response by the trust detailing the actions taken:**<br>A review has taken place to ensure appropriate storage and security of COSHH products. Information poster has been put in place at relevant location. Staff have been reminded to adhere to COSHH storage standards as per Trust policy. Assurance arrangements are in place through staff meetings, audit and daily checking / reinforcement. |
| **Area for Improvement 3**<br><br>**Ref**: 6.3.1(f)<br><br>**Stated:** Second<br><br>**To be completed by:**<br>11 March 2020 | Improvement is required to the fabric, fixtures and fittings of the **Emergency Department**. Remedial work should be undertaken to maximise the therapeutic environment for patients and clients. |
| | **Response by the trust detailing the actions taken:**<br>A review has taken place and programme of work developed to improve ED fabric, fittings and fixtures. Work plan continues to be implemented but in certain this is challenged due to ongoing pandemic and red zone area within ED. |

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| **Area for Improvement 4**<br><br>**Ref**: Standard 6.3.1(c)<br><br>**Stated:** Second<br><br>**To be completed by:**<br>11 March 2020 | The Trust must ensure there is a policy and procedure in place for the use of CCTV in the 'secure room' in the **Emergency Department**. The policy must provide clear guidelines about:<br><br>• the circumstances when it would be appropriate to use CCTV;<br>• documentation of decision making around its use;<br>• the frequency of review of each episode of use; and<br>• whose responsibility it is to review its use.<br><br>The Trust must implement assurance mechanisms to ensure CCTV is being used in line with the policy. |
| | **Response by the trust detailing the actions taken:**<br>The service team are working with Safe and Effective team to take this forward and develop protocol that adds to already existing arrangements. Progress has been impacted by current pandemic. This will be completed during Quarter 2, by 30th September 2020. The secure room is in red zone, and use for this purpose has drastically decreased due to pandemic. |

***Please ensure this document is completed in full and returned to** BSU.Admin@rqia.org.uk **from the authorised email address****

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