Unannounced Follow up Inspection Report
13 and 14 February 2018

Ross Thomson Unit

Acute Psychiatric Inpatient Ward
Causeway Hospital
4 Newbridge Road
Coleraine

Tel No: 028 70346114

Inspectors: Alan Guthrie and Nan Simpson

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Assurance, Challenge and Improvement in Health and Social Care

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 provider from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

Ross Thomson Unit is 20 bedded acute psychiatric inpatient ward located beside the Northern Health Care Trust's Causeway Hospital. The ward provides care and treatment to male and female patients suffering from acute mental health problems. On the days of inspection there were 17 patients on the ward. Seven patients had been detained to the ward in accordance with the Mental Health (Northern Ireland) Order 1986.

3.0 Service details

Responsible person: Dr Anthony Stevens	**Ward Manager:** Ronan Mountcastle
Category of care: Mental Health	**Number of beds:** 20
Person in charge at the time of inspection: Ronan Mountcastle	

4.0 Inspection summary

An unannounced follow-up inspection took place over two days on 13 and 14 February 2018.

The inspection sought to assess progress with findings for improvement raised from the most recent unannounced inspection which took place 11 – 13 October 2016.

The purpose of the inspection was to meet with patients and staff and to review the 11 areas for improvement identified from the previous unannounced inspection completed on 11 – 13 October 2016. Findings from the inspection evidenced a number of positive developments and continued progress towards addressing all the areas for improvement previously identified. However, concerns remained regarding the ward's environmental configuration.

On the days of the inspection the inspector and the lay assessor evidenced the ward was appropriately staffed. The atmosphere was relaxed and patients were moving freely throughout the main ward areas. Patients presented as being at ease in their surroundings and staff were patient focussed and attentive. Two patients were receiving continued nursing support on a one to one basis.

The ward was generally clean and appropriately presented. Inspectors noted that the ward's garden area contained smoking debris. The ward manager assured inspectors that a cleaning rota for the garden was available and the outside area was cleaned on a regular basis. Patients who met with inspectors indicated no concerns regarding their relationships with staff and the care and treatment provided to them. Interactions between staff and patients were observed by inspectors as being patient centred, friendly and supportive. Inspectors evidenced that the ward contained a large number of ligature points. A ligature risk assessment had been completed on

the 10 October 2017. The assessment identified areas where ligature risks were noted. Inspectors evidenced that 103 ligature points had been assessed as requiring action. The action detailed that he ligature point should be removed, replaced or covered. . However, the ligature assessment did not identify a timeline or plan within which these actions would be implemented. An area for improvement regarding this has been made.

Since the last inspection the trust had appointed a new ward manager. The manager had introduced a number of changes and it was positive to note that the ward's nursing staffing levels had stabilised and that there was limited use of agency nursing staff. Nursing staff who met with inspectors were positive about the ward and reported no concerns regarding their roles and responsibilities.

Inspectors reviewed four sets of patient care records. Generally, records were noted to be comprehensive, up to date and easy to follow. Each patient had a comprehensive assessment, risk assessment and care plan based on their assessed needs. The ward had introduced a new multi-disciplinary team (MDT) template and the ward manager continued to complete regular audits of patient care records to ensure appropriate standards were being maintained.

Inspectors reviewed the 11 areas for improvement and evidenced that the trust had made significant progress in addressing each of the areas identified. Nine of these areas had been met. One area for improvement had been partially met and one area had not been met.

Areas for improvement which were assessed as met included: management of patients' mobile phones, updating fire safety and evacuation procedures, addressing staffing levels and vacancies, increasing patient/staff meetings and further developing carer participation in care planning for patients. The evidence verifying inspectors' findings for each of these areas for improvement is discussed below.

One area for improvement had been partially met. Inspectors reviewed four sets of patient care records and evidenced that risk assessments were available for each patient. These where evidenced as being comprehensive and based on the assessed needs of the patient. However, one patient's comprehensive risk assessment (CRA) (PQC 2010) had not been completed in accordance the standards detailed in PQC guidance. The patient had received a comprehensive violence and risk management assessment (HCR assessment) and a supporting care plan had been produced. Whilst the patient's risk assessment was not being managed in accordance to regional guidance, inspectors had no concerns regarding the patient's care plan or how the patient's presenting risks were being managed. It is also important to note that prior to completing the inspection inspectors were informed that the patient's CRA would be reviewed at a risk strategy meeting to be convened on the 15 Feb 2018. This area for improvement will be restated for a second time in the quality improvement plan (QIP) accompanying this report.

One area for improvement had not been met. Since October 2016 services within the Ross Thomson unit had increased with the introduction of the Causeway Hospital's Rapid Assessment Interface Discharge (RAID) team and the Mental Health Wellness Hub. Inspectors identified that the privacy, confidentiality and dignity of inpatients was being compromised due to outpatients having to directly access the ward to attend the trust's mental health crisis response service. It is important to recognise that the trust's mental health directorate had reviewed the unit's environment and structural alterations had been proposed. However, the changes proposed would require significant capital investment and an extended timeline to

complete. Due to the seriousness of this concern RQIA wrote to the trust's Chief Executive and the Director of Mental Health services to ask that they review the unit's configuration to ensure that outpatients did not access the inpatient facility.

Inspectors identified five new areas for improvement. The ward's ligature risk assessment plan did not detail a timeline or action plan to address ligature points needing to be replaced or removed. Four of the five ward toilets reviewed did not have ventilation systems that worked. Furthermore the use of two patient call systems located within each toilet required review. Alert pull cords were missing in each toilet and call buttons located on the wall were located on the opposite wall to the toilet.

The ward had a fully equipped gym. The gym was not used to its full potential as there were only two staff trained to provide supervision to patients when using the gym equipment.

The final new area for improvement related to the door connecting the ward to the main hospital. Inspectors noted that the glass on the door was clear and patients' privacy was compromised as members from the public could see into the ward.

Patients stated

The lay assessor met with six patients. Patients presented as being content and at ease in their surroundings and with staff. Four patients stated that they were very satisfied with the ward and that they felt care was safe, effective, compassionate and well led. Two patients' stated that they were satisfied with their care and treatment. This included one patient who had been admitted to the ward the previous day and remained unwell.

Patient comments included:

"Staff were excellent and knew I was coming to the ward".

"Very kind staff".

"I feel supported and safe".

"More activities at the weekend would be good".

"OT's are brilliant".

"Sometimes there is not enough staff".

"Staff are brilliant they have helped me so much".

"Staff are very good".

"Activities during the week are good but Saturdays and Sundays are very long and boring".

"No complaints the care is very good. I am very happy with my stay on this ward".

"Good food".

"Generally …very happy with the care provided in this unit".

"The ward is better that it was before".

Inspectors reviewed the ward's staffing levels and the nursing staff rota. Inspectors evidenced that staffing levels were generally good and there were robust measures in place to address staff shortages. The ward's management team and nursing staff who spoke with inspectors reported that the flexibility and commitment of the unit's nursing staff meant that shifts with nursing staff shortages were addressed quickly.

Relatives stated

No relatives were available to meet with the inspectors on the days of the inspection.

Staff stated

Inspectors met with 11 members of staff representative of all professions within the ward's MDT.

Staff who met with inspectors stated they felt the care and treatment provided to patients was safe, compassionate, and effective and patient centred. The ward's medical staff stated that the MDT was effective and that ward staff provided a high standard of care to patients. Patient access to psychotherapeutic interventions had improved and the ward's clinical psychologist attended the ward on a regular basis. The psychologist provided ward staff with supervision and support in relation to delivering low-level psychological interventions with patients. They also participated in case discussions with staff and group work with patients and staff. Staff informed inspectors that they had no difficulties regarding their ability to access training and supervision.

Staff comments included:

"Ward meetings are very good".

"There is good support from senior staff".

"Managers are approachable."

"The nursing staff are very good".

"There is not always enough staff".

"I am very impressed with the staff team in Ross Thomson".

"Sometimes when Obs (continued one to one support for patients) increase there are not enough nursing staff".

"The crisis response team provides good support to the ward".

Four staff questionnaires were completed during the inspection. Staff were asked to rate a serious of questions relating to is the ward safe, is care compassionate, effective and is the ward well led The rating scale ranged from 1 = very unsatisfied to 5 = very satisfied. Of the 20 areas rated staff responded with 20 ratings of very satisfied or satisfied.

The findings of this report will provide the trust with the necessary information to assist them to fulfil their responsibilities, enhance practice and service user experience.

4.1 Inspection outcome

Total number of areas for improvement	Seven

The seven of areas for improvement comprise:

- 2 restated for a second time
- 5 new areas of improvement

These are detailed in the Quality Improvement Plan (QIP). Areas for improvement and details of the QIP were discussed with senior trust representatives, members of the multi-disciplinary team, the ward manager and ward staff as part of the inspection process. The timescales for completion commenced from the date of inspection.

5.0 How we inspect

The inspection was underpinned by:

- 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.

The following areas were examined during the inspection:

- Psychology and behaviour support service.
- Care Documentation in relation to four patients.
- Ward environment.
- Advocacy service.
- Activity schedule.
- Timetable for sharing best practice.

We reviewed the areas for improvements made at the previous inspection and an assessment of compliance was recorded as met/partially met and not met.

6.0 The inspection

6.1 Review of areas for improvement from the last unannounced inspection 11 – 13 October 2016

The most recent inspection of the Ross Thomson was an unannounced inspection. The completed QIP was returned and approved by the responsible inspector. This QIP was validated by inspectors during this inspection.

Areas for Improvement from last inspection		Validation of Compliance
Area for improvement 1 **Ref**: 5.3.1 (a) **Stated:** First time	<u>Access to the ward</u> **Action taken as confirmed during the inspection**: This area for improvement remained unchanged. Structurally the building design remained the same. Local measures had been put in place to escort outpatients through parts of the ward. The waiting room for the Crisis response service had also been moved to within the same area where the Crisis response service was based. Furthermore the Trust had moved two other services into the same area. The general hospitals RAID team and the mental health HUB had moved in since the last inspection. Subsequently, inpatients privacy was being affected. Inspectors were informed that the Trust has plans in place to redesign certain aspects of the building. Staff who met with inspectors reflected positively on crisis response, raid and health HUB colleagues being located within the same building. Good examples of close partnership working were also discussed. However, a number of staff also discussed the challenges of manging some outpatients who wander onto the ward by accident. This area for improvement was not met. Given the concerns evidenced by inspectors the Trust's Chief Executive and the ward's senior management team was contacted through RQIA serious concerns policy and procedures. This area for improvement will be restated for a second time in the QIP	**Not met**

	accompanying this report. A further follow up inspection has also been arranged for the 13 August 2018. This inspection will follow up the Trust's progress in addressing this area.	
Area for improvement 2 **Ref**: Standards 5.3.1 (c) & 6.3.2 (a) **Stated:** First time	<u>Mobile Phones</u> **Action taken as confirmed during the inspection**: Inspectors reviewed the ward's mobile phone, policy and procedures, associated staff check lists and the information provided to patients. The ward's mobile phone policy clearly stated that patients should not share information on social media regarding the ward environment, pictures of other patients or ward activities. Failure to comply could result in the patient being asked to give their phone to staff or have it removed. Each patient was asked to sign the checklist which quoted the policy. Supporting patient information regarding phone use was detailed and appropriate. None of the patients who met with the lay assessor reported any concerns regarding their ability to retain and use their phone. No patients detailed any issues regarding their privacy being breeched.	**Met**
Area for improvement 3 **Ref**: 5.3.1(f) **Stated:** First time	<u>Fire Safety Policy and Evacuation Procedures</u> **Action taken as confirmed during the inspection**: A major incident grab box was available and included the following information: • A map layout of the ward. • A copy of the Trust's corporate major incident plan (updated in February 2016). • An environmental risk audit assessment completed 10 December 2016. (The fire standard was no. 23 in the assessment and included five indicators. Indicators related to fire risk assessment, fire training for staff, the appointment of fire officers and fire	**Met**

	safety checks. The ward had been assessed as compliant). • The ward's fire safety policy and evacuation procedure. The inspector also noted that the ward's fire safety was discussed and reviewed at the Trust wide fire safety group.	
Area for improvement 4 **Ref**: Standard 6.3.1 (a) **Stated:** First time	<u>Staffing Issues</u> **Action taken as confirmed during the inspection**: The ward's nursing staff rota detailed that the ward ran with and early shift (5 trained and 2 untrained nursing staff), a long day shift (five trained and 2 untrained nursing staff) and a night shift (three trained and 1 untrained nursing staff). The ward continued to use bank nurse staff although this had reduced since the previous inspection. The ward nursing staff team had three vacant posts at the time of the inspection. The vacancies (2 trained and 1 untrained nursing staff) were subject to the Trust's recruitment processes. A number of factors supported the ward's nursing staff complement when the ward was under staffing pressures (for example when nursing staff were providing direct observations to more than two patients or high staff sickness) these factors included: • A new nurse management team and associated stability. • The commitment and flexibility of core nursing staff who were willing to complete shifts at short notice. • Support from senior managers. • Productive and supportive working relationship with the staff co-ordinator at Holywell hospital. This enabled the quick relocation of nursing staff from Holywell hospital when required. As a standalone unit the nursing staff management team continued to closely monitor staffing levels and requirements. The inspector was assured that the ward did not use agency nursing staff unless	**Met**

	absolutely necessary and that bank nursing staff completing shifts were familiar with the ward, the needs of patients and the associated care and treatment pathways. The inspector reviewed the ward's occupational therapy (OT) staffing levels. The ward was supported by one band 6 OT and two OT technicians.	
Area for improvement 5 **Ref**: 5.3.1(f) **Stated:** First time	<u>Risk Documentation and Recording</u> **Action taken as confirmed during the inspection**: The inspector reviewed four sets of patient records. Risk assessments were available for each patient. These where evidenced as being comprehensive and based on the assessed needs of the patient. However, one patient's comprehensive risk assessment (CRA) (PQC 2010) had not been completed in accordance the standards detailed in PQC guidance. The patient had a CRA completed on the 11-12-2016. A CRA review was scheduled to take place on the 22 Feb 2017 but this was cancelled. Subsequently the patient was transferred to the Ross Thomson unit on the 11 May 2017. The inspector could find no evidence detailing that the patient's CRA had been reviewed in accordance to guidance. It is important to note that the patient's presenting risk remained closely assessed and monitored by the ward's MDT. The patient had received a comprehensive violence and risk management assessment (HCR assessment) and supporting plan. An area of improvement regarding the completion of CRA has been made. Prior to completing the inspection inspectors was informed that the patient's CRA will be reviewed as a priority at a risk strategy meeting on the 15 Feb 2018.	**Partially met**
Area for improvement 6 **Ref**: 5.3.1 (f) **Stated:** First time	<u>Multi-Disciplinary Recording at Zoning Meetings</u> **Action taken as confirmed during the inspection**: The ward's MDT zoning meeting template had been reviewed and amended. The inspector evidenced that the name of each MDT member	**Met**

	was recorded and their contribution to the meeting noted**.** It was positive to note that the new template also included a pre meeting consultation record of patient views/requests. Patients could also attend the meeting on request should they wish to do so.	
Area for improvement 7 **Ref**: 5.3.3 (f) **Stated:** First time	<u>Patients do not have Access to a Quiet Room</u> **Action taken as confirmed during the inspection:** The ward manager had identified two rooms where patients could access quiet space. This included a small box room and the ward's family room. The inspector reviewed both rooms and noted that they could be accessed by patients as required.	**Met**
Area for improvement 8 **Ref:** 6.3.1 (b) **Stated:** First time	<u>Patient Forum Meetings</u> **Action taken as confirmed during the inspection**: The inspector reviewed the patient meeting records. Meetings took place on a regular basis and the date and time of meetings was displayed on the ward's patient information notice board located in the main corridor. Records from meetings evidenced that patient requests were recorded and followed up. In circumstances were requests could not be met the reasons for this were explained.	**Met**
Area for improvement 9 **Ref**: 5.3.1 (f) **Stated:** First time	<u>Accessing up-to-date Trust Policies</u> **Action taken as confirmed during the inspection**: The inspector reviewed six trust policies relevant to the ward. Policies could be accessed by all staff through the Trust's intra net. Five out of the six policies were evidenced as being up to date. One policy '*Drug and Substance Misuse Free Environment in a Mental Health inpatient Setting'* was out of date. The inspector evidenced that this policy was subject to review and would be updated in the near future. The inspector was satisfied that Trust policies were being appropriately reviewed, updated and managed.	**Met**

Area for improvement 10 **Ref:** 6.3.2 (b) **Stated:** First time	Carer Participation in Co-Producing Care Plans **Action taken as confirmed during the inspection**: Care records reviewed by the inspector evidenced that patient's relatives/carers were involved in the patients care. Records evidenced that ward staff liaised with family members on a regular basis and family were involved in initial assessments, care planning meetings (were appropriate), update and risk strategy meetings and discharge planning meetings. Patients reported no concerns regarding their relative's involvement in patient care and treatment.	**Met**
Area for improvement 11 **Ref**: 6.3.2 **Stated:** First time	Recording of Cancelled Activities **Action taken as confirmed during the inspection**: OT activities were available daily. In circumstances where an activity had to be cancelled this was recorded in patients' notes, team meeting minutes and in the daily MDT HUB/Handover meetings. Nurse led activities were provided in the evenings and at weekends when possible. The inspector noted that the ward provided care and treatment to 20 patients presenting with acute mental health problems. Subsequently, in circumstances where patients required consistent 1 to 1 nursing support these duties had to be prioritised over group activities. The inspector noted that the ward had a fully equipped gym. However, only two staff had the necessary training to support patients' use of the gym equipment.	**Met**

7.0 Quality Improvement Plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with senior trust representatives, members of the multi-disciplinary team, ward manager and ward staff as part of the inspection process. The timescales commence from the date of inspection.

The responsible person must ensure that all areas for improvement identified within the QIP are addressed within the specified timescales. The responsible person should note that failure to comply with the findings of this inspection may lead to escalation action being taken.

7.1 Actions to be taken by the service

The quality improvement plan should be completed and detail the actions taken to meet the areas for improvement identified. The responsible person should confirm that these actions have been completed and returned via the web portal for assessment by the inspector by **11 April 2018**.

Quality Improvement Plan

The responsible person must ensure the following findings are addressed:

Area for Improvement No. 1 **Ref:** 5.3.1 (a) **Stated:** Second Time **To be completed by:** 13 August 2018	Access to the ward **Response by responsible individual detailing the actions taken:** Service has updated procedures for patients accessing the ward from other teams. Patients from Crisis Resolution and Home Treatment Team (CRHTT) have a private waiting area and are always escorted in and out of building by CRHTT staff. Only time patient under CRHTT or Community Mental Health Team (CMHT) are supervised on the ward are when they are classed as 'Self-Presenters' and are managed under a separate policy for the service. CRHTT review these patients at earliest opportunity, usually within an hour of presenting to the ward. Since last RQIA inspection service has continued to look at changes to access of the building that are cost effective and maintain patient safety and dignity during contact with the ward and other Mental Health Teams within Causeway Hospital. Outcome of this review will be forwarded to RQIA within two months.
Area for Improvement No. 2 **Ref:** 5.3.1 (f) **Stated:** Second time **To be completed by**: 14 March 2018	Risk Documentation and Recording. **Response by responsible individual detailing the actions taken:** Patient concerned has had three formal reviews of their risk assessment since admission to Ross Thomson Unit (RTU) in May 2017. Community Forensic Team has completed a HCR-20 Risk Assessment in October 2017. The third review occurred following RQIA inspection where it was clarified for RTU, Ballymoney CMHT and Community Forensic Team staff that specialist risk assessments are in addition to CRAs under PQC guidance and do not replace an individual's CRA. RTU have updated patient's CRA and this will be reviewed by RTU and CMHT before the end of May 2018. The issue was also discussed at RTU multi-disciplinary business meeting at the beginning of April 2018. Further discussions due to take place about how PQC patients are handed over from another team/ward current CRA status is included. Options include updating formulation meeting paperwork, discharge/transfer paperwork and regular audits of Integrated Care Pathway (ICP) to ensure outstanding risk assessments are completed correctly and in a timely manner.

Area for Improvement No. 3 **Ref:** 5.3.1 (e) **Stated:** First time **To be completed by:** 13 August 2018	The ward's ligature risk assessment should include an action plan and timeline as to when ligature points requiring removal or replacement will be completed.
	Response by responsible individual detailing the actions taken: A ligature audit has been completed and engagement is on-going with Estates Department to progress any risks as a matter of priority. A series of collaborative meetings have been arranged with Estates and all ward managers will track requests for Estates intervention and monitor completion of tasks.
Area for Improvement No. 4 **Ref:** 5.3.1 (f) **Stated:** First time **To be completed by:** 13 August 2018	The trust should ensure that ventilation systems within ward toilets are working.
	Response by responsible individual detailing the actions taken: Request forwarded to Estates Department on 14 February 2018. Resubmitted 4 April 2018 (reference number 652129) for a check of all toilet areas. Estates Department informed Ronan Mountcastle (Ward Manager) on 6 April 2018 that this job would be completed by 20 April 2018.
Area for Improvement No. 5 **Ref:** 5.3.1 (f) **Stated:** First time **To be completed by:** 13 August 2018	The trust should ensure that alert systems within ward toilets are working and easy for patients to access.
	Response by responsible individual detailing the actions taken: Request forwarded to Estates Department on 14 February 2018 and resubmitted on 4 April 2018 (reference number 652131) for a check and review of alert systems in these areas. Estates Department informed Ronan Mountcastle on 6 April 2018 that this job would be completed by 20 April 2018.
Area for Improvement No. 6 **Ref:** 5.3.3 (d) **Stated:** First time **To be completed by:** 13 August 2018	The trust should ensure that there is a sufficient number of staff trained to provide patients with support to use the ward's cardiovascular gym equipment.
	Response by responsible individual detailing the actions taken: Physio Service and Mental Health Service asked to review the need for high cost training for all staff who supervise the Gym. This will include ensuring any potential changes to current training do not put patients at risk of injuries and that staff are adequately trained in this area before they supervise patients. Information provided to the Nursing Services Manager on 5 April 2018 by RTU Lead Physiotherapist in relation to what courses are available in relation to this activity

Area for Improvement No. 7 **Ref:** 6.3.2 (a) **Stated:** First time **To be completed by:** 13 May 2018	The trust should ensure that the door connecting the ward to the main hospital building does not compromise patient privacy.
	Response by responsible individual detailing the actions taken: Minor Works request submitted to ensure windows on two doors concerned are obscured in order to protect patient dignity (reference number 652510). Estates Department advised Ronan Mountcastle on 6 April 2018 that works would be completed by 20 April 2018.

Name of person (s) completing the QIP	Ronan Mountcastle		
Signature of person (s) completing the QIP		**Date completed**	6th April 2018
Name of responsible person approving the QIP	DR TONY STEVENS		
Signature of responsible person approving the QIP		**Date approved**	12/4/2018
Name of RQIA inspector assessing response	Alan Guthrie		
Signature of RQIA inspector assessing response		**Date approved**	18/4/2018

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