Unannounced Inspection Report
13 March 2019

Western Health and Social Care Trust
Carrick and Evish Wards
Grangewood Hospital
Gransha Park
Londonderry
BT47 6TF

Tel No: 028 7186 0261/028 7186 4379

Inspectors: Cairn Magill and Fionnuala Breslin

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 service

Evish and Carrick are 15 bedded acute mental health inpatient wards for the assessment and treatment of patients experiencing mental ill health situated in Grangewood Hospital. Both inpatient wards accommodate patients between the ages of 18 and 65. Female patients are accommodated in Evish and male patients are accommodated in Carrick. The wards operate as part of a single-system mental-health crisis response service. This includes a crisis response, home treatment team and an acute day care service. These services are offered to patients in the first instance to prevent admission to hospital.

Bedrooms in both wards are single rooms with en-suite bathrooms. The design of the building lends itself to being flexible. There are 30 single bedrooms between each ward. When required, one ward can utilise up to three bedrooms off the other ward to accommodate higher numbers thereby reducing the number of bedrooms available in the other ward whilst still maintaining separate male and female wards. Each ward also has a separate corridor that has the capacity to accommodate up to three patients in a Psychiatric Intensive Care Unit (PICU).

There is a multi-disciplinary team which includes consultant psychiatrists; doctors; nurses; occupational therapists and social workers. A pharmacist visits the wards every week. Patients had access to a physiotherapist, and clinical psychology therapy service by referral. A patient and carer advocacy service is also available for patients receiving care on the wards.

On the day of the inspection there were nine patients on Evish and one patient on home leave. Three patients were detained in accordance with the Mental Health (Northern Ireland) Order 1986 (The Order). There were 16 patients on Carrick ward; six of whom were detained in accordance with The Order.

3.0 Service details

Responsible person: Dr Anne Kilgallen, Chief Executive Officer Western Health and Social Care Trust (WHSCT)	**Ward Manager:** Mr Tony Simmons
Category of care: Acute mental health	**Number of beds:** Carrick 15 Evish 15
Person in charge at the time of inspection: Mr Tony Simmons	

4.0 Inspection Summary

An unannounced inspection took place on the 13 March 2019 from 09:30 hours to 15:30 hours.

This inspection was undertaken by two care inspectors.

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 and The Quality Standards for Health and Social Care DoH (March 2006).

This inspection was undertaken following concerns about patient safety from a relative who contacted RQIA on 13 and 17 December 2018. The concerns related to a series of deaths in Carrick as a result of patients completing suicide during 2013, 2015, 2016 and 2018. The tragic death in 2018 had involved this relative's son. Additional information in this regard can be found in section 6.3.1 of this report.

In January 2019, RQIA received a formal complaint from the same relative raising concerns about our role in holding the WHSCT to account in relation to patient safety both during inspections and on receipt of information relating to serious adverse incidents (SAIs). Following each SAI, the Trust completes an investigation into the incident and produces a final report. All SAI reports should follow the Health and Social Care Board (HSCB) Procedure for the Reporting and Follow up of Serious Adverse Incidents (2016).

As a result of the information received from the relative; we re-examined the final SAI reports generated following two inpatient deaths that occurred during 2015 and 2016 as both patients used the en-suite door as a ligature point. The en-suite door had also been a contributing factor in the patient's death in 2018. The final SAI reports pertaining to incidents that occurred during 2017 and 2018 were not complete at the time of this inspection. Review of the final SAI reports generated following the two inpatient deaths that occurred during 2015 and 2016 identified key lines of focus which we examined during this inspection. Our inspection focused on:

- the recognition and management of adverse incidents and near misses;
- the implementation of learning arising from the SAI reports; and
- establishing if recommendations made within SAI reports had been addressed.

We visited both inpatient wards and reviewed the care and treatment processes. We evidenced the following outcomes:

Areas of good practice:

- we found staff to have good knowledge of safeguarding procedures in relation to children visiting patients on the wards;
- we observed good information on display at the ward's entrance outlining the purpose of the ward and informing visitors of the wards performance;
- we found the wards to be clean and welcoming with adequate space for patients to use for activities or quiet time;
- we observed good information on display for patients outlining their rights, the advocacy service available and the staff on duty;
- we found evidence of regular patient /staff meetings taking place and there was evidence that issues raised by patients had been addressed;

- we confirmed that patient information is collated upon admission to inform risk assessments and care plans;
- we confirmed that an addictions liaison nurse had been appointed to provide an in reach service to patients; and
- we observed staff engaging with patients in a warm and compassionate manner.

We were concerned that:

- the fire Incidents were not reported appropriately in accordance with the Health and Social Care Board (HSCB), Procedure for the Reporting and follow up of Serious Adverse Incidents, November 2016;
- there was no evidence that; learning from fire incidents had been shared with staff and embedded into practice; that the arrangements in relation to risk assessments and management of ignition sources had been updated, and staff training was not robust; and
- the arrangements in relation to the management of adverse incidents and near misses were not sufficiently robust to identify trends and patterns, there was no evidence to confirm that learning arising from incidents was shared with appropriate staff and that actions to mitigate against potential risks had been actioned.

4.1 Inspection Outcome

Total number of areas for improvement	Six

Six areas for improvement were identified against the standards in relation to:

- ensuring that comprehensive risk assessments are completed for patients prior to admission;
- the arrangements in respect of reporting serious adverse incidents;
- the arrangements in respect of incident management;
- ensuring that debrief sessions are undertaken following incidents;
- the arrangements in respect of ignition sources; and
- the arrangements in respect of Pro Re Nata (PRN) medication.

Details of the Quality Improvement Plan (QIP) were discussed with Mr Tony Simmons, ward manager, members of the multi-disciplinary team and members of the Trusts Senior Management Team as part of the inspection process. The timescales for implementation of these improvements commence from the date of this inspection.

4.2 Enforcement taken following this inspection

In response to concerns identified during our inspection we invited Senior Trust representatives to a serious concerns meeting in the offices of RQIA on 25 March 2019. At this meeting we discussed our concerns in relation to the management of adverse incidents and near misses; fire safety and progressing recommendations within SAI and RQIA reports.

Senior Trust representatives attended the serious concerns meeting, where the required actions to address our concerns were agreed. These actions are described throughout this report. During this meeting, the Trust representatives told us they acknowledged and recognised the seriousness of the inspection findings and the importance of ensuring that steps are taken to address the identified concerns in a timely manner to reduce the risks to patient safety.

On 15 April 2019 an action plan outlining the proposed actions to address the concerns identified was submitted to RQIA. This action plan was satisfactory and addressed our concerns and identified key personnel who were responsible for seeing actions through to completion.

5.0 Inspection Summary

Prior to inspection a range of information relevant to the service was reviewed. This included the following records:

- previous inspection reports;
- serious adverse incident notifications and subsequent reports;
- information on concerns;
- information on complaints; and
- other relevant intelligence received by RQIA.

Each ward was assessed using an inspection framework. The methodology underpinning our inspections includes; discussion with patients and relatives; observation of practice; focus groups with staff and review of documentation. Records examined during the inspection include: nursing records; medical records; senior management and governance reports; minutes of meetings; duty rotas and training records.

Areas for improvement identified at the previous inspection were reviewed and an assessment of achievement was recorded as met, partially met, or not met.

Findings of this inspection were shared with Mr Tony Simmons, ward manager, members of the multi-disciplinary team and members of the Trusts Senior Management Team at the conclusion of the inspection. As previously mentioned, the inspection findings were also discussed with Trust representatives during a serious concerns meeting in the offices of RQIA on 25 March 2019.

6.0 The Inspection

6.1 Review of areas for improvement from the previous inspection on 12 and 13 September 2017

The most recent inspection of Carrick and Evish was an unannounced inspection undertaken on 12 and 13 September 2017.

The completed QIP was returned by the Trust to RQIA and was subsequently approved by the care inspector.

6.2 Review of areas for improvement from the previous inspection on 12 and 13 September 2017

Areas for improvement		Validation of compliance
Area for improvement No. 1 **Ref:** Standard 5.3.1 (f) **Stated:** First time	In a number of MDT templates it did not name who the responsible person was for completing each action.	**Met**
	Action taken as confirmed during the inspection: We randomly selected and reviewed four patient records and confirmed that the name of the MDT member responsible for completing each action was clearly recorded.	
Area for improvement No. 2 **Ref:** Standard 5.3.1 (f) **Stated:** First time	Concerns were raised regarding the under reporting of a serious adverse incidents which happened on the ward on 12 August 2017. This incident met the criteria for investigation under the HSCB, Procedure for the Reporting and Follow up of Serious Adverse Incidents, November 2016. It is concerning to note that this is the second time RQIA have had to raise this issue with the Trust.	**Not met**
	Action taken as confirmed during the inspection: Staff told us that a fire had occurred on Carrick on 12 February 2019 and that a further three fires had occurred on Carrick over the previous 12 calendar months. These incidents met the criteria for investigation under the HSCB, Procedure for the Reporting and Follow up of Serious Adverse Incidents, (November 2016). These incidents had not been reported to RQIA or the HSCB in line with the regional procedures. This area for improvement has not been met. A new area for improvement has been made in regards to incident reporting. Additional information in this regard can be found in section 6.3.5 of this report.	
Area for improvement No. 3 **Ref:** Standard 5.3.1 (a)	Previous comprehensive risk assessments completed for patients by other mental health services prior to their admission to the wards, had not been migrated over to the current risk assessment.	**Not assessed**

Stated: First time	**Action taken as confirmed during the inspection:** This area for improvement was not assessed and has been reworded and carried forward for review at the next inspection.	
Area for improvement No. 4 **Ref:** Standard 4.3 (i) **Stated:** First time	Access to the baby and mother unit should be reviewed as this unit was situated at the end of the ward therefore this could create unnecessary risks to young children/babies when they are brought to visit their mother	**Met**
	Action taken as confirmed during the inspection: We reviewed the arrangements for children/babies to visit their mother in the baby and mother unit. We confirmed that the baby and mother unit can only be accessed by going through the main ward. Due to the design and layout of the ward the baby and mother unit cannot be relocated. As the baby and mother unit cannot be relocated measures have been put in place to mitigate the potential risks identified as a result of having to access the unit through the main ward. Mr Simmons told us that staff escort and chaperone children/babies to and from the unit every time they enter or leave via the main ward. Staff told us that prior to children/babies visiting their mother a risk assessment is completed by the multi-disciplinary team. We evidenced that the staff were managing the risks of children and babies visiting the ward.	
Area for improvement No. 5 **Ref:** Standard 6.3.2 (a) **Stated:** First time	The garden areas were unkempt. Both garden areas were not a therapeutic space for patients to relax in.	**Met**
	Action taken as confirmed during the inspection: A new contractor was appointed to maintain the gardens. We observed that the hedges had been cut back and that work to maintain the gardens was ongoing. We found the gardens to be a therapeutic space for patients to relax in.	

Area for improvement No. 6 **Ref:** Standard 5.3.1 (f) **Stated:** Second Time	The MDT template did not always evidence if actions agreed at the meeting had been completed.	**Met**
	Action taken as confirmed during the inspection: We were informed that when actions agreed at multi-disciplinary team meetings had been completed this was recorded in the patient records and the ward diary. As discussed under area for improvement 1 above we reviewed patient records and evidenced this. We found the current system to be working effectively.	
Area for improvement No. 7 **Ref:** Standard 5.3.1 (f) **Stated:** Second Time	Medicine kardex did not always record the indication for Pro Re Nata (PRN) medication and whether it was to be administered as 1st line or 2nd line.	**Not met**
	Action taken as confirmed during the inspection: We randomly selected and reviewed two medicine kardexes' in order to review the management of Pro Re Nata (PRN) medications. We noted that one kardex clearly recorded that two PRN medications had been given at the same time. The PRN instructions clearly indicated that one of the medicines should be administered in the first instance, and that if required, the second medicine should be administered if the first medication did not have the desired result. The management of PRN medications had been identified as a concern during previous inspections undertaken on 25-27 October 2016 and 12-13 September 2017. This area for improvement has not been met. A new area for improvement has been made in respect of PRN medications. Additional information in this regard can be found in section 6.3.8 of this report.	
Area for improvement No. 8 **Ref:** Standard 4.3.(j) **Stated:** Second Time	There was no clinical psychologist attached to the wards to form part of the MDT.	**Met**
	Action taken as confirmed during the inspection: Mr Simmons and senior Trust representatives told	

	us that the Trust were experiencing difficulties recruiting dedicated clinical psychologists to provide a service to acute inpatient mental health wards. Despite not having a dedicated clinical psychologist patients are referred to the clinical psychology department, where appropriate and that the Trust are committed to recruiting dedicated clinical psychology staff.	

6.3 Inspection Findings

6.3.1 Relative concerns

This inspection was undertaken following concerns about patient safety from a relative who contacted RQIA on 13 and 17 December 2018. The concerns raised with RQIA related to four deaths by suicide between 2013 and 2018 of patients being cared for on Carrick.

In January 2019 RQIA received a formal complaint from the same relative raising concerns about our role in holding the WHSCT to account in relation to patient safety both during inspections and on receipt of information relating to SAI's.

The complaint received by this relative was subject to RQIA's complaints procedure. The complaint was upheld and RQIA apologised to the complainant for our failing to hold the WHSCT to account. The complainant has requested that RQIA publish the name of their son, Davin Corrigan in the report of this inspection and to reflect that as a result of the learning arising from this complaint we have strengthened our internal processes for examining all intelligence we receive. Upon receipt of any new information, we review all sources of information logged against the service. This will include re-examining SAI reports and the recommendations within them; reviewing all concerns including whistleblowing and safeguarding referrals and identifying any trends or themes emerging. This process enables more effective regulatory decision-making and the information will support the development of key lines of inquiry to underpin our inspections.

6.3.2 Serious Adverse Incidents (SAIs)

As discussed in section 4.0 of this report, prior to this inspection, we reviewed the final SAI reports generated following two inpatient deaths on Carrick that occurred during 2015 and 2016. We noted a significant delay from the date of the incidents occurring to the date the Trust completed the final SAI report. One report was received five months post incident and one was received 17 months post incident. We also noted that the recommendations within SAI reports did not identify a timeframe for completion or identify a person responsible for ensuring recommendations were implemented. The timeframes to complete the final SAI report and the recommendations and action planning sections of the SAI reports were not in accordance to the HSCB Procedure for the Reporting and Follow up of Serious Adverse Incidents.

We were not assured that all recommendations within SAI reports have been actioned. An area for improvement has been made. This is discussed in more detail in section 6.3.3 below.

6.3.3 Implementation of learning from Serious Adverse Incidents (SAI's)

We met with Mr Simmons, and a number of ward based staff to assess their understanding of the SAI process. We found that nursing staff had some level of awareness of the process and the recommendations contained within the most recent SAI reports. However, they were unsure who was responsible for ensuring that recommendations were actioned. Staff had some understanding that various departments within the Trust roles in progressing the implementation of recommendations. For example, in relation to one SAI recommendation, staff reported that they knew alternative anti-ligature doors were being sourced to replace the en-suite doors but they were unsure of the stage the Trust was at between scoping suitable anti-ligature doors through to the purchase, and installation of the new doors. They were also unsure who had the overall responsibility to progress the work.

We reviewed two sets of minutes the from Trust's Clinical and Social Care Governance meetings that occurred on 6 June 2018 and 21 November 2018. These evidenced some discussion around a number of SAI recommendations. However, the minutes lacked detail and did not include information in relation to the specific steps required to fully implement the recommendations, the timeframe for completion or who had been assigned responsibility for progressing recommendations.

We reviewed minutes of the ward team meetings that occurred on 21 November 2018 and 5 December 2018 and found evidence of some discussion in relation to implementing learning arising from the SAI reports. We found no evidence of any assurance system to test if identified learning had been shared with staff, evaluated and embedded into practice.

Senior representatives from the Trust who attended the feedback session at the end of this inspection acknowledged the delay, from the date of incidents occurring to the completion of the SAI review, was significant. The Trust had recently implemented a weekly live governance meeting to identify those incidents that require an immediate review.

We identified a number of concerns in relation to the management of SAIs. These were:

- the time delay between an incident occurring and the completion of the final SAI report;
- the recommendations within SAI reports did not have associated timeframes for completion of actions;
- the responsibility for ensuring recommendations made within SAI reports were actioned was not clearly assigned;
- the identified learning not being shared with appropriate staff, embedded into practice and audited; and
- the limited oversight of the implementation of SAI recommendations by relevant governance committees.

An area for improvement has been made to address the issues identified above.

6.3.4 Removal of en-suite doors

We confirmed that the SAI report relating to the incident that occurred during November 2016, which we received in on 31 May 2018, recommended that; *"the proposed business case for the replacement/upgrade of the current en-suite doors in the Grangewood Hospital will be taken forward."* On 20 November 2018, we were informed by the Assistant Director of the WHSCT that the WHSCT were in the process of sourcing new en-suite doors.

We received confirmation from the WHSCT on 25 February 2019 that the en-suite doors throughout Grangewood hospital had been removed and replaced with anti-ligature doors and that wardrobe doors were removed also. We undertook a walk-around of the wards and confirmed that all en-suite doors in both wards had been replaced with non-weight bearing saloon type doors. We tested the doors and were assured that they would collapse if weight were applied. We also noted all wardrobe doors in patients' bedrooms were removed as they too would have presented a ligature risk.

6.3.5 Incident management

We reviewed the WHSCT incident management policy and procedure. The policy was dated 2014 and was due for review during 2017. The HSCB Procedure for the Reporting and Follow up of Serious Adverse Incidents was updated in November 2016. Therefore, the Trust's incident management policy did not reflect the current HSCB SAI procedure.

We asked staff to tell us about adverse incidents that had occurred on the ward since our previous inspection on 12 and 13 September 2017. We were told that a fire had occurred on Carrick on 12 February 2019 and that three other fires had occurred within the previous 12 months. These incidents met the criteria for reporting as an SAI, as outlined in the HSCB Procedure for the Reporting and Follow up of Serious Adverse Incidents. However, none of these incidents had been recorded as a SAI or reported to RQIA.

In relation to the four fires we were told about, in each case the fire was deliberately started by a patient using a lighter. However, we did not see evidence at local level or within the Trust's governance systems that these incidents had been audited to identify trend analysis. There was no evidence that local or corporate policies and procedures had been updated in relation to patient access to ignition sources; that risk assessments had been updated following each incident; that learning had been shared with staff and embedded into practice and that staff training had been updated. We were also concerned that there was no record of any post-incident debrief discussions having occurred.

We are concerned that the arrangements in relation to incident management are not sufficiently robust to mitigate risk and maintain the safety of patients and staff. An area for improvement has been made in this regard.

6.3.6 Reporting incidents via regional procedures

As discussed in section 6.3.5 above, we identified four incidents that met the threshold for reporting as an SAI that had not been reported. We were told by Trust representatives that the failure to report these events as SAI's was attributable to staff failing to complete all aspects of Datix (the electronic incident reporting system) correctly.

Incidents should be graded according to risk. We were told that staff had graded these incidents as low risk because no harm had occurred to patients. We reinforced that grading of incidents should not solely be based on outcome and that consideration should be given to the potential level of risk. The way in which these incidents were graded affected the escalation of the incidents to the Trust Senior Management team and relevant governance structures. These incidents were not escalated as SAIs as per regional procedures. We are concerned that the current system was not sufficiently robust to recognise incidents as SAI's when they occur and treat them accordingly. An area for improvement has been made in this regard.

6.3.7 Fire Safety

As discussed we confirmed that four fires had occurred in Carrick since the previous inspection. We discussed these incidents with Mr Simmons and reviewed the fire officer's report for the most recent fire which occurred on 12 February 2019.

We noted the following issues:

- the Northern Ireland Fire & Rescue Service attended the fire and attempted to disperse the smoke after the fire was supressed by installing a number of high speed fans. The fans circulated the smoke which in turn triggered other smoke detectors not only in Carrick but also in Evish. This resulted in the alarms sounding for an additional ninety minutes causing distress to patients in Evish;
- there was no evidence that a formal incident debrief occurred post incident; and
- there was no evidence that a review of patient access to ignition sources had been completed as specified in the report by The Trust's Fire Officer dated 14 February 2019, as follows: The report stipulated that; *"the manager/service manager must undertake an immediate review of management arrangements re: client access to ignition sources whilst admitted to the ward as this is the 4th incident of this nature in the past 12 months at this property- indicating that current arrangements are not adequate."*

We found no evidence during the inspection, that a review of fire safety arrangements on the ward was undertaken as recommended in the Fire Officer's report. There was no updated information shared with staff regarding managing patient access to ignition sources. These matters were discussed in depth at the end of the inspection with Mr Simmons, members of the multi-disciplinary team and members of the Trusts Senior Management Team. An area for improvement has been made in this regard.

6.3.8 Medicine Management

During the inspection we randomly selected and reviewed two medicine kardexes' in order to review the management of Pro Re Nata (PRN) medications. We noted that one kardex clearly recorded that two PRN medications had been given at the same time. The PRN instructions clearly indicated that one of the medicines should be administered in the first instance, and that if required, the second medicine should be administered if the first medication did not have the desired result. The kardex did not specify the indications for PRN medication or the time interval between the administration of the two medicines.

The management of PRN medications had been identified as a concern during previous inspections undertaken on 25-27 October 2016 and 12-13 September 2017. An area of improvement has been made in this regard.

6.3.9 Staffing Levels

We reviewed the arrangements in respect of staffing levels. Mr Simmons informed us that each ward required a minimum of four registered nurses and two nursing assistants for the day shift and one registered nurse and two nursing assistants for the night shift. These numbers increased to a total of seven nursing staff during the day and four or five nursing staff at night time if either ward had patients in PICU. Mr Simmons informed us that the Trust had made a decision not to use agency staff to cover shifts except in an emergency situation. All staff shortages for shifts were primarily sourced through the Trust's own banking office.

We reviewed the staff duty rota for Carrick and found there were 15 shifts covered by bank staff during the week of the inspection. Mr Simmons, the deputy manager and nurses in charge reported that most of their time was dominated by the task of ensuring adequate cover for the wards. They further reported that when the banking office could not identify cover from the bank team, the nurse in charge of the ward spent a large amount of time contacting staff to request they work additional shifts. We were informed that when ward staff could not cover shifts, a staff nurse based in the Home Treatment Crisis Response team would be based on the ward to ensure there was adequate staff cover. This in turn reduced the capacity of nurses to respond to the care needs of patients in receipt of services from the Home Treatment Crisis Response Team.

We were concerned that there was an insufficient pool of staff to cover the ward and even on days that staff were scheduled to have off they were more often than not called upon to cover a shift. We were also concerned that the flexible approach to the PICU impacted on staffing requirements for the wards and the level of instability created by the flexible approach to PICU had a direct impact on the staff team.

We discussed these issues with the Trust's Senior Management Team at the end of the inspection. We were informed, that the Trust had identified the need for each ward to have its own ward manager as the role of managing two wards was challenging for one ward manager. We were informed that the Trust were in the process of recruiting two additional ward managers one for Grangewood hospital and one for Tyrone and Fermanagh hospital. During the discussion it was acknowledged that there was shortage of nursing staff across the region.

6.4 Patient experience and feedback

During the course of the inspection we met with four patients. Two patients told us they felt care on the ward was safe while two stated they did not feel care on the ward was safe. The two patients who told us they did not feel that care was safe indicated that their reasons for their views related to their care plans which indicated they should be ward based. Both patients disagreed with their care plans regarding needing to be ward based. We reviewed their care plans and discussed their concerns with staff and determined that the patient's individual care plans and risk assessments were clear in relation to their need to be ward based.

Two patients told us that there was not enough staff on duty. This was discussed with the ward manager who advised that it was challenging to ensure adequate cover for the ward.

One patient reported that their care on the ward was compassionate, effective and well-led and stated that they are involved in discussions about their treatment plan and medications.

6.5 Patient experience and feedback

We spoke with Mr Simmons and other nursing staff members.

Staff told us they believed, overall the care on the wards was compassionate, effective and that the wards were well led. However, they also reported that there were times the ward struggled to ensure there was sufficient staff cover on duty.

As discussed in section 6.3.9 of this report issues in relation to staffing levels were discussed at the conclusion of the inspection with the Trust's Senior Management Team.

Total number of areas for improvement	Six

7.0 Quality improvement plan (QIP)

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mr Simmons, ward manager; members of the multi-disciplinary team and members of the Trusts Senior Management team during feedback delivered on 13 March 2019. They were also discussed during our serious concerns meeting held in the offices of RQIA on 25 March 2019. The timescales commence from the date of this inspection.

The Trust should note that if the actions outlined in the QIP are not taken to comply with 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 in which action is required to ensure compliance with The Mental Health (Northern Ireland) Order 1986 and The Quality Standards for Health and Social Care DoH (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 to BSU.admin@rqia.org.uk for assessment by the inspector by **7 August 2020.**

Quality Improvement Plan	
This inspection is underpinned by The Mental Health (Northern Ireland) Order 1986 and The Quality Standards for Health and Social Care DoH (March 2006).	
Risk Assessment	
Area for Improvement No. 1 **Ref:** Standard 5.3.1 (a) **Stated:** First Time **To be completed by:** 8 November 2017	The Western Health and Social Care Trust (WHSCT) shall address the following matters with respect to Risk Assessments: • ensure that comprehensive risk assessments completed by other mental health services are received prior to patients admission to the wards; and • ensure that these are maintained and updated while the patient remains on the ward. **Ref: 6.2**
	Response by the Trust detailing the actions taken: The Western Health and Social Care Trust (WHSCT) with respect to risk assessment operate a electronic records system (PARIS). Here risk assessments, completed by any involved community team can be accessed on admission by inpatient services.These are maintained and updated while the patient remains on the ward. Risk assessments are audited monthly.

Serious Adverse Incidents (SAIs)	
Area for Improvement No. 2 **Ref:** Standard 5.3.2 **Stated:** First Time **To be completed by:** Immediate and ongoing	The WHSCT shall address the following matters with respect to Serious Adverse Incidents (SAIs): • ensure the recommendations and action plan must adhered to the Guidance on Minimum Standards for Action Plans as outlined in Appendix 8 of the HSCB Procedure for the Reporting and Follow up of Serious Adverse Incidents (November 2016); and • ensure that all SAI's are reported in accordance with the HSCB guidance document entitled ' Procedure for the Reporting and Follow up of Serious Adverse Incidents (November 2016) • an update of action items listed in the recommendations should be reviewed through the Directorate's Governing systems. **Ref: 6.2, 6.3.2, 6.3.3**
	Response by the Trust detailing the actions taken: The Western Health and Social Care Trust adhere to the Guidance on Minimum Standards for Action Plans as documented in Appendix 8 of the HSCB Procedure for the Reporting and Follow up of SAI (2016). All SAI's are reported in accordance with this guidance and approved weekly at Rapid Review Group (RRG) prior to submission. Action plans are shared with staff across the directorate and through Governance meetings. All action items listed within the RQIA Quality Improvement Plan are reviewed through the appropriate Governance structures and the plan is a standing item on the agenda within the Directorate Governance fortnightly meetings.

Incident Management	
Area for Improvement No. 3 **Ref:** Standard 5.3.1 (f**)** **Stated:** Second Time **To be completed by:** 13 October 2019	The WHSCT shall address the following matters with respect to incident management: • the WHSCT incident management policy and procedure dated 2014 should be updated to fully reflect the Health and Social Care Board (HSCB) guidance document entitled 'HSCB Procedure for the Reporting and Follow up of Serious Adverse Incidents, (November 2016)'; • the updated policy should be shared with staff; • appropriate staff should complete training with regard to recording incidents on the Datix system; and • incidents recorded on Datix should be audited to ensure all incidents that meet the threshold for reporting as a SAI in accordance with HSCB guidance have been reported. **Ref: 6.3.5 & 6.3.6**
	Response by the Trust detailing the actions taken: The Western Health and Social Care Trust is currently in the process of updating the 2014 Incident Reporting Policy utilizing the Regional HSCB guidence document "Procedure for the Reporting and Follow up of SAI" (2016). Due to Covid-19 the Trust did not meet the recommended deadline date of 30th June 2020 but it aims to have this completed by the end of August 2020. In the interim phase the 2014 policy with updated risk matrix(2016) is still extant. Once updated this policy will be shared with all staff within Western Health and Social Care Trust. Inpatient staff have completed the appropriate training (inputters and handlers training) with regard to recording incidents on the datix system.This is now a rolling program to ensure that key staff are trained within a timely fashion. On a monthly basis both Service Managers from the in-patient facilities audit 10 Datix incidents each. The purpose of this audit is to ensure the appopriate grading of incidents (escalation to upgrading and reporting) alongside the trend analysis per facility. All red incidents are discussed and reviewed weekly at RRG to ensure that incidents that meet the threshold are reported to the HSCB.

Area for improvement No. 4 **Ref:** Standard 5.3.2 **Stated:** First Time **To be completed by:** Immediate and ongoing	The WHSCT shall address the following matters with respect to incident debrief: • a local incident debrief policy and procedure should be developed and implemented; • the policy should be shared with staff; • a record must be maintained for all incident debrief sessions undertaken; and • any learning identified as a result of incident debrief sessions must be shared with staff and actioned. Senior members of the Trust should ensure there are localised formal incident debrief sessions following adverse incidents. These should be recorded at ward level for reference and learning. **Ref: 6.3.5 & 6.3.6**
	Response by the Trust detailing the actions taken: The WHSCT has developed an incident debrief procedure which is guided by our Risk Management policy 2019. The policy and procedure has been shared with staff in draft form for comment and feedback. A record has been maintained of all incident debrief sessions. Lessons learned as a result of incident have been shared with staff and actioned.
Fire Safety	
Area for improvement No. 5 **Ref:** Standard 5.3.1 **Stated:** First Time **To be completed by:** 13 November 2019	The WHSCT shall address the following matters with respect to ignition sources: • a local policy and procedure to manage and mitigate the risks associated with patients accessing ignition sources must be developed and implemented; and • the policy must be shared with staff. **Ref: 6.3.7**
	Response by the Trust detailing the actions taken: The WHSCT has developed a new procedure to manage and mitigate the risks associated with patients accessing ignition sources which is guided by our Fire prevention policy. This policy and procedure has been shared with staff.

Medicines Management	
Area for Improvement No. 6 **Ref:** Standard 5.3.1.(f) **Stated:** Third Time **To be completed by:** Immediate and ongoing	The WHSCT shall address the following matters with respect to Pro Re Nata (PRN) medication: • medicine kardexes must record the indication for PRN medication and whether prescribed PRN medicines are to be administered as first or second line medications; • medicine kardexes must include minimum time intervals between the administration of the first and second line medications; • following administration of PRN medications the outcome for the patient must be documented; and • a rolling audit programme must be developed to provide assurance that the medicine kardexes are being fully completed and that staff are adhering to the PRN prescription, consideration should be given to involving the ward pharmacist in the audit programme. **Ref: 6.3.8**
	Response by the Trust detailing the actions taken: An audit of the documentation of these areas as detailed above was performed in June 2019 in both acute inpatient wards in Grangewood Hospital, Evish and Carrick. Following analysis of these results three training sessions on PRN prescription and documentation were delivered by our Clinical Pharmacist in Autumn 2019 for all staff at Grangewood Hospital. A re-audit was to be performed in early Spring 2020 however due to Covid-19 and fluctuating staffing levels this was postponed. A re audit was performed at random in May 2020 in both acute wards in Grangewood. From this re-audit, that there has been a significant improvement in the documentation of PRN medications in Grangewood hospital. Even with changing staff over a year, the expectations for documentation are being communicated. This rolling audit programme will continue and be extended to the wards in T+F.

Please ensure this document is completed in full and returned to RQIA via the web portal

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