Unannounced Enforcement Inspection Report
13 - 14 November 2019

Western Health and Social Care Trust

Carrick and Evish Wards
Grangewood Hospital; Gransha Park, Clooney Road, Londonderry
BT47 6TF

Tel No: 028 7186 0261 & 028 7186 4379

&

Elm and Lime Wards
Tyrone and Fermanagh Hospital, 1 Donaghanie Road, Omagh
BT79 0NS

Tel No: 028 8283 5366 & 028 8283 5368

Membership of the Inspection Team

Dr Lourda Geoghegan	Director of Improvement and Medical Director Regulation and Quality Improvement Authority
Dr John Simpson	Senior Medical Advisor Regulation and Quality Improvement Authority
Lynn Long	Assistant Director, Improvement Directorate Regulation and Quality Improvement Authority
Emer Hopkins	Deputy Director, Improvement Directorate Regulation and Quality Improvement Authority
Wendy McGregor	Senior Inspector, Hospital Programme Team Regulation and Quality Improvement Authority
Cairn Magill	Inspector, Hospital Programme Team Regulation and Quality Improvement Authority
Carmel Treacy	Inspector, Hospital Programme Team Regulation and Quality Improvement Authority
Rhona Brennan	Inspector, Hospital Programme Team Regulation and Quality Improvement Authority
Norma Munn	Inspector, Independent Health Care Team Regulation and Quality Improvement Authority
Stephen O'Connor	Inspector, Independent Health Care Team Regulation and Quality Improvement Authority
Raymond Sayers	Estates Inspector Regulation and Quality Improvement Authority
Stuart Brown	ADEPT Fellow Regulation and Quality Improvement Authority
Paulina Spychalska	Inspection Coordinator Regulation and Quality Improvement Authority
Gary McMaster	Inspection Coordinator Regulation and Quality Improvement Authority
Alan Craig	Lay assessor

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

Within the Western Health and Social Care Trust (the Trust), there are four acute mental health admission wards for people aged between 18 and 65. These wards provide assessment and treatment for patients with acute mental health needs. Patients are admitted either on a voluntary basis or in accordance with the Mental Health (Northern Ireland) Order 1986 (MHO).

Carrick and Evish wards are situated in Grangewood Hospital, within Gransha Park, Londonderry. Carrick is a 15 bedded male ward and Evish is a 15 bedded female ward. Bedrooms in both wards are single rooms with en-suite bathrooms. The design of the building lends itself to increasing the number of female or male beds whilst keeping the wards gender specific. A Psychiatric Intensive Care Unit (PICU) with the capacity to accommodate up to three patients can also be created between the two wards.

Elm and Lime wards are situated in Tyrone and Fermanagh (T&F) Hospital, Omagh. Elm is a 13 bedded female ward and Lime is a 13 bedded male ward. Both wards have single and double bedrooms and three and four bedded dorm rooms. Between the two wards, there is an adjoining PICU, which can accommodate four patients.

Patients in both hospitals had access to a multi-disciplinary teams that includes; consultant psychiatrists; doctors; nurses; occupational therapists and social workers. A pharmacist/pharmacy technician visits the wards every week. Patients had access to a physiotherapist, and clinical psychology therapy service by referral. A patient and carer advocacy service was also available for patients receiving care on the wards.

The Trust's mental health inpatient units 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.

3.0 Service details

Responsible person: Dr Anne Kilgallen, Chief Executive Officer Western Health and Social Care Trust (The Trust)	**Ward Managers:** **Carrick:** Ms Kellie Mc Gilloway **Evish:** Mr Tony Simmons **Elm:** Ms Mary Maguire **Lime:** Mr Joe McLaughlin
Category of care: Mental Health Acute Care	**Number of beds:** Carrick: 15 Evish: 15 Elm: 13 Lime: 13
Person in charge at the time of inspection: Head of Service, Crisis, Primary Care and Addictions, Grangewood Hospital Head of Service / Lead Nurse, Tyrone and Fermanagh Hospital	

4.0 Inspection summary

We undertook an unannounced inspection to Carrick and Evish wards (Grangewood) and Elm and Lime ward (T&F) over two days commencing on 13 November 2019 and concluding on 14 November 2019 from 08:45 to 17:00.

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).

On 22 July 2019 RQIA issued an Improvement Notice (IN) to the Trust in respect of a failure to comply with minimum standards. This inspection sought to assess the level of compliance achieved in relation to the IN. The areas identified for improvement and compliance with the minimum standards were in relation to the implementation of a robust system for the recognition and management of adverse incidents and near misses. The date by which compliance with the IN must be achieved was 22 October 2019.

We did not find sufficient evidence to validate full compliance with the IN. We found evidence of some improvement and progress made against all of the required actions within the IN. Following this inspection, we held two meetings with the Chief Executive and members of the senior management team on 20 December 2019 and 22 January 2020. At this meeting we were provided with further assurances regarding the progress being made towards compliance.

RQIA's senior management held a meeting on 22 January 2020 and a decision was made that the date of compliance for this IN (IN000002) should be extended. Compliance with this notice must therefore be achieved by 22 June 2020. The extended Improvement Notice – IN000002E was issued on 5 February 2020.

Following our unannounced inspection undertaken between 3 and 5 June 2019 we met with senior representatives from the Trust on 10 July 2019 to discuss five areas of serious concerns we had identified during our inspection.

These concerns related to:

1. the safe management of hospital environments;
2. organisational governance;
3. incident management;
4. patient physical health needs; and
5. the Psychiatric Intensive Care (PICU) model

Subsequently the Trust submitted information to RQIA, in the form of an action plan, detailing the actions they had taken and continued to take to address the serious concerns. We reviewed the Trust progress with respect to these five areas of concern as part of this inspection. Additional information can be found in section 6.2 below.

4.1 Inspection outcome

Total number of areas for improvement	15*

Total number of Improvement Notices	1 (Extended)

**There are 15 areas for improvement arising from this inspection, comprising of ten areas for improvement stated for the first time, and five areas for improvement which have been stated for a second time. These are detailed in the QIP.

Details of the QIP were discussed with; the Chief Executive and members of the senior management team as part of the inspection process. The timescales for implementation of these improvements commence from the date of this inspection.

Ongoing enforcement action resulted from the findings of this inspection. As a result of this inspection the date of compliance with the Improvement Notice, IN000002 was extended to 22 June 2020.

The enforcement policies and procedures are available on the RQIA website.

https://www.rqia.org.uk/who-we-are/corporate-documents-(1)/rqia-policies-and-procedures/

Improvement Notices for Trusts are published on RQIA's website at https://www.rqia.org.uk/inspections/enforcement-activity/current-enforcement-activity with the exception of children's services.

5.0 How we inspect

Following the previous inspection between 3 and 5 June 2019, we held a meeting with the senior management team (SMT) on 10 July 2019. At this meeting, the SMT presented the actions they had taken to address the serious concerns. We tested the information they provided during this inspection. We also reviewed a range of information relevant to the service including the following records:

- previous inspection reports;
- Serious Adverse Incident (SAI) notifications and reports;
- written and verbal information received following the previous care inspection in June 2019; and
- complaints received by RQIA.

We assessed each ward using a standardised inspection framework. The methodology underpinning our inspections included; discussions with patients; observations of practice; interviews with staff; and a review of relevant documentation. We examined samples of records during the inspection which included: nursing care records; medical records; SMT and governance reports; minutes of meetings; duty rotas; and staff training records.

Posters informing patients, staff and visitors of our inspection were displayed while our inspection was in process.

We invited staff to complete an electronic questionnaire during the inspection. We received one returned completed staff questionnaires following this inspection.

A lay assessor was present during the inspection and their comments are included within this report.

Findings of this inspection were shared with the Chief Executive and members of the Trust senior management team at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the previous inspection on 3 - 5 June 2019

This inspection focused on the five action points contained within Improvement Notice IN000002 issued on 22 July 2019. Ten out of 17 areas for improvement, from the last inspections of Carrick and Evish on 13 March 2019, Elm and Lime on 24 – 25 October 2017 and Carrick Evish, Elm and Lime on 3, 4 and 5 June 2019 were not reviewed as part of this inspection and are carried forward to the next inspection. The QIP in section 7.2 reflects the carried forward areas for improvement.

At the time of undertaking this inspection, the previous report and QIP of the inspection undertaken between 3 and 5 June 2019 had not been issued to the Trust. However, the areas for improvement were discussed with the senior management team in detail at the conclusion of the inspection and during the serious concerns meeting held in RQIA on 10 July 2019.

6.2 Review of areas for improvement from the previous inspection on 3-5 June 2019

Quality Improvement Plan		
Action required to ensure compliance with The Quality Standards for Health and Social Care DoH (March 2006)		**Validation of Compliance**
Carried forward from Previous Carrick and Evish QIP of inspection dated 13/03/2019		
Risk Assessments		
Area for Improvement 1 **Ref**: Standard 5.3.1 (a) **Stated:** Second time	The senior management team 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.	**Carried forward to the next inspection**
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to a subsequent inspection.	

Incident Debrief		
Area for Improvement 2 **Ref**: Standard 5.3.1 **Stated:** Second time	The senior management team 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.	**Not Met**
	Action required to ensure compliance with this standard was reviewed and progressed as part of the Improvement Notice issued on 22 July 2019. The date of the compliance with the Improvement Notice has been extended as a result of this inspection and compliance must be achieved by 22 June 2020.	
Fire Safety		
Area for improvement 3 **Ref:** Standard 5.3.2 **Stated:** Second time	The Trust senior management team shall address the following matters with respect to ignition sources: • develop a local policy and procedure to manage and mitigate the risks associated with patients accessing ignition sources; and • ensure the policy is shared with staff.	**Met**
	Actions taken as confirmed during the inspection: This area for improvement has been assessed as met and further detail is provided in section 6.5.2.	

Carried forward from previous Elm and Lime inspection dated 24-25 October 2017		
Nurse Training on Psychological Formulation		
Area for Improvement 4 **Ref**: Standard 4.3 (m) **Stated:** First time	The senior management team shall develop a training programme to ensure staff have the skills and knowledge to complete care plans which are based on psychological formulations.	**Carried forward to the next inspection**
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to a subsequent inspection.	
Areas for improvement from the previous inspection 3-5 June 2019		
Staffing Mandatory Training		
Area for improvement 5 **Ref**: Standard 5.3.1 **Stated:** First time	The senior management team shall develop an action plan to address deficits in staff mandatory training.	**Carried forward to the next inspection**
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to a subsequent inspection.	
Adult Safeguarding		
Area for improvement 6 **Ref**: Standard 5.3.1 **Stated:** First time	The senior management team shall develop an action plan to address deficits in staff adult safeguarding training. The action plan shall also include the development and implementation of a rolling audit programme that provides the Trust with an assurance mechanism that all staff are competent and are adhering to the Trust's regional safeguarding policies.	**Partially Met**
	Actions taken as confirmed during the inspection: This area for improvement has been assessed as partially met and further detail is provided in section 6.5.1.	

Management of incidents and risk		
Area for improvement 7 **Ref**: Standard 5.3.1 **Stated:** First time	The senior management team should review the ligature risk assessments for each ward and ensure that any action plans generated as a result of the risk assessments are actioned in a timely manner. The environmental ligature risk assessment should be a live document and not solely conducted on an annual basis. Areas identified for action must be regularly reviewed and should be updated when they are completed.	**Carried forward to the next inspection**
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to a subsequent inspection.	

<table>
<tr><th colspan="3">Management of Medicines</th></tr>
<tr><td rowspan="2">Area for improvement 8

Ref: Standard 5.3.1

Stated: First time</td><td>The Trust senior management shall address the following issues in relation to medicine management;
ensure there is a robust system in place with regard to stock control of medicines;
there are no expired medicines or medicine prescribed to patients that have been discharged retained in ward stock;
all discontinued or unwanted ward/patient medicines should be returned to the pharmacy/patient as applicable and in a timely manner;
ensure stocks of the same medicine are stored in the same place in the stock cupboards;
ensure all medicines are stored in their original packaging or pharmacy containers;
ensure a copy of the record for the disposal of medicines, sent to the hospital pharmacy, is retained on the ward; and
should review and consider enhancing pharmacy support in both hospitals.</td><td rowspan="2">Carried forward to the next inspection</td></tr>
<tr><td>Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to a subsequent inspection.</td></tr>
<tr><th colspan="3">Resuscitation and management of medical emergencies</th></tr>
<tr><td rowspan="2">Area for improvement 9

Ref: Standard5.3.1

Stated: First time</td><td>The Trust resuscitation officers should audit access to resuscitation trolleys across all wards and ensure that all relevant staff can assess this equipment in an emergency.</td><td rowspan="2">Carried forward to the next inspection</td></tr>
<tr><td>Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to a subsequent inspection.</td></tr>
</table>

Infection Prevention Control (IPC)		
Area for improvement 10 **Ref**: Standard 5.3.1 (f) **Stated:** First time	The Trust shall address the following matters in relation to infection prevention and control: • improve the standard of ward cleanliness; paying particular attention to ward sanitary wear and equipment storage areas; • commence a programme of decluttering and reorganisation of storage areas; • take action and provide assurance that staff are managing linen and waste in line with the Trust's policy; • improve the cleaning and organisation of domestic cleaning equipment and stores. Robust monitoring of these areas should be in place to provide continued assurance; and • take action to improve staff adherence to the Trust's policies on hand hygiene, use of personal protective equipment and uniform and dress. Robust monitoring should be in place to provide continued assurance.	**Carried forward to the next inspection**
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to a subsequent inspection.	

Environment		
Area for Improvement 11 **Ref**: Standards 4.3 and 5.3.1 **Stated:** First time	In respect of T&F the Trust shall address the following matters in relation to the environment: • undertake a survey of the interior fabric of the wards and generate an action plan to repair or replace any issues identified. Particular attention should be paid to floors; walls; lightening and ceilings; review the water safety/legionella risk assessment for the facility and implement any recommended improvements/control measures to reduce the potential risk of legionella bacteria in the water system; • submit to RQIA a suitable and sufficient fire risk assessment for the wards, any recommended action plan items must be noted with a completion date. RQIA must be informed of the completion or delay of any works action plan items, as works proceed; • ensure that oxygen cylinders are stored away from direct sunlight and undertake a risk assessment regarding the exterior glass door in the clinical room of Lime; • ensure the environment and furniture in the psychiatric intensive care unit (PICU) shared between Elm and Lime meet the required safety standard for a PICU; paying particular attention to glazing; install a clinical hand washing basin in the clinical room of PICU; and • remedial works should be undertaken to ensure a therapeutic outdoor environment for patients. In respect of Grangewood the Trust shall submit the following documentation to RQIA upon return of this quality improvement plan (QIP): • an updated fire risk assessment, an action plan generated as a result of this risk assessment. A progress report detailing the actions taken to address actions identified in the action plan to include timeframes; and • an updated risk assessment and water hygiene survey report following 11 October 2019 assessment.	**Partially Met**

	Actions taken as confirmed during the inspection: This area for improvement has been assessed as being partially met and further detail is provided in section 6.5.2. This area for improvement will be stated for the second time.	
Management of Patient's Property and Finances		
Area for Improvement 12 **Ref**: Standard 5.3.1 **Stated:** First time	The Trust shall ensure that all relevant staff are familiar with the policy and procedure for securing and managing patient's property and finances with particular regard to; • recording patient items against the correct patient; • accurate entries are made in patient finance records; and adherence to the policy and procedure for amending errors. The Trust shall: • update and complete regular financial audits at ward level to assure themselves that the Trust's policy in relation to the Management of Patient's Property and Finances is being adhered to; and • ensure the audit identifies when and who areas of concern should be escalated to, if applicable.	**Carried forward to the next inspection**
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to a subsequent inspection.	

<table>
<tr><th colspan="3">Physical Health Care</th></tr>
<tr><td rowspan="2">Area for improvement 13

Ref: Standard 5.3.3

Stated: First time</td><td>The Trust shall address the following matters in relation to physical health care needs:
undertake a review of specialist consultant input for patients with an eating disorder; and
review the system for monitoring patients who are subject to fluid restriction to ensure that all patients with hyponatraemia are being managed in accordance with NICE Clinical Guidance CG174.</td><td rowspan="2">Not Met</td></tr>
<tr><td>Actions taken as confirmed during the inspection:
This area for improvement has been assessed as not met and further detail is provided in section 6.5.4.</td></tr>
<tr><th colspan="3">Therapeutic Activity</th></tr>
<tr><td rowspan="2">Area for improvement 14

Ref: Standards 5.3.3
6.3.1
6.3.2

Stated: First time</td><td>The Trust shall review and enhance patient engagement in relation to therapeutic activities and patient engagement with particular regard to:
reviewing the provision of therapeutic activities; to include evenings, weekends and bank holidays. The review should consider the type of activities and how and where it is delivered;
ensure the results of patient experience questionnaires are shared with staff. An action plan should be generated to improve service delivery; and
ensure that patient experience feedback is considered, measure, monitored and informs pieces of quality improvement work.
Ward managers should ensure patient/staff meetings occur on a regular and consistent basis. The minutes of meetings should refer back to items discussed at the previous meeting and note any follow-up taken to address issues discussed.</td><td rowspan="2">Carried forward to the next inspection</td></tr>
<tr><td>Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to a subsequent inspection.</td></tr>
</table>

<table>
<tr><th colspan="3">Organisational Governance</th></tr>
<tr><td rowspan="2">Area for Improvement 15

Ref: Standard 4.3

Stated: First time</td><td>The Trust shall address the following matters with respect to the governance arrangements across the adult mental health and disability directorate:
undertake a rapid review of the Trusts governance structures to determine what committees/forums and meetings are required in order to assure best practice;
the role and responsibilities of each committee need to be clearly delineated to ensure there is no ambiguity with respect to who has overall responsibility for clinical governance, operational management and any other relevant roles within the directorate. All roles need to be clearly defined and specified;
governance structures within the directorate should be shared with staff; and
Grangewood and T&F governance structures should be closely aligned to ensure equity in relation to patient flow and care pathways; and that quality improvement initiatives are integrated across the directorate.</td><td rowspan="2">Partially Met</td></tr>
<tr><td>Actions taken as confirmed during the inspection:
This area for improvement has been assessed as being partially met and further detail is provided in sections 6.5.3.</td></tr>
</table>

<table>
<tr><th colspan="3">PICU Operating Model</th></tr>
<tr><td rowspan="2">Area for improvement 16

Ref: Standard 4.3

Stated: First time</td><td>The Trust shall review the arrangements in respect of the psychiatric intensive care units (PICUs). The review should consider the NAPICU, National Minimum Standards for Psychiatric Intensive Care Adult Service, (September, 2014) and include:
bed occupancy, patient need, staffing, levels of observation and ability to respond to emergencies and out of hours admissions;
identification of normative nursing staffing levels for each inpatient ward to include nursing capacity to undertake joint medical and nursing assessments for admissions; and
a review of the E-rostering system ensuring that bank shifts are easily identified and the system is user friendly.</td><td rowspan="2">Not Met</td></tr>
<tr><td>Actions taken as confirmed during the inspection:
This area for improvement has been assessed as not met and further detail is provided in section 6.5.5.</td></tr>
</table>

<table>
<tr><th colspan="3">Audits</th></tr>
<tr><td rowspan="2">Area for Improvement 17

Ref: Standard 4.3

Stated: First time</td><td>The Trust shall address the following matters with respect to audits:
undertake a review of the rolling audit programme to ensure it provides the Trust with the necessary assurances in relation to the standard of care;
undertake a review of audit tools to ensure they are user friendly and in accordance with best practice guidance and evidence base;
ensure a consistent approach to audits is undertaken across the northern and southern areas within the directorate;
ensure that robust arrangements are established to escalate issues identified during the audit process through the directorate’s governance structures; and
consideration must be given to how audit findings are analysed for trends/comparative data, and how audit findings are shared with relevant governance committees; staff and patients.</td><td rowspan="2">Carried forward to the next inspection</td></tr>
<tr><td>Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to a subsequent inspection.</td></tr>
</table>

6.3 Inspection findings

Improvement Notice Ref: IN000002

STATEMENT OF MINIMUM STANDARDS

The Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS (March 2006).

Standard 5.1

Safe and effective care is provided by the HPSS to those service users who require treatment and care. Treatment or services, which have been shown not to be of benefit, following evaluation, should not be provided or commissioned by the HPSS.

5.3 Criteria

5.3.1 Ensuring Safe Practice and the Appropriate Management of Risk

The organisation:

(b) acknowledges and promotes the central place that patients, service users and carers have in the prevention and detection of adverse incidents and near misses;
(f) has properly maintained systems, policies and procedures in place, which are subject to regular audit and review to ensure: awareness raising and staff knowledge of reporting arrangements for adverse incidents and near misses, and whistleblowing arrangements when poor performance and/or unsafe practice in examination, treatment or care comes to light;

5.3.2 Preventing, Detecting, Communicating and Learning from Adverse Incidents and Near Misses

The organisation:

(a) has systems and processes in place to prevent, identify, assess and manage and review adverse incidents and near misses across the spectrum of care and support provided;
(b) promotes an open and fair culture, rather than one of blame and shame, to encourage the timely reporting and learning from adverse incidents and near misses;
(c) has reporting systems in place to collate, analyse and learn from all adverse incidents, and near misses, share knowledge and prevent reoccurrence of adverse incident or near miss; and
(d) has systems in place that promote ongoing communication with service users and carers when treatment or care goes wrong, and puts in place an individual care plan to minimise injury or harm.

In relation to this notice the following five actions were required to comply with the standards.

The Chief Executive, executive team and director of adult mental health & disability services must:

- undertake an urgent review of information recorded in the Trust's Datix system, to ensure that they understand the nature and extent of risks captured in the system as it operates across the Trust's directorate of adult mental health & disability services;

- take action to address and mitigate specific patient safety risks (individual, themes and/or trends) identified as part of the above review and ensure these risks are appropriately addressed in a timely manner;

- assure themselves that staff across the directorate of adult mental health & disability services have sufficient knowledge, awareness and understanding of adverse incidents and near misses, so that they (incidents and/or near misses) are appropriately recognised and accurately recorded in the Trust's Datix system. The grading of adverse incidents and near misses must be based on the risk inherent in each event and not on the outcome reported for the event in question;

- ensure that there are appropriate structures in place to review, approve, and escalate all incidents, adverse incidents and near misses captured in the Trust's Datix system as it operates across the directorate of adult mental health & disability services and demonstrate that mechanisms for assuring this dynamic process are sufficiently robust; and

- design and implement processes to ensure that i) they are regularly updated on the spectrum of adverse incidents and near misses occurring across the directorate of adult mental health & disability services, ii) all incidents and near misses are graded on inherent risk, iii) appropriate mitigating actions have been identified and progressed in relation to risks identified, iv) learning arising from incidents and near misses has been identified and shared with all relevant staff, and v) they and Trust Board receive appropriate assurance(s) regarding the operation of these processes.

6.3.1 Incident Management

We gathered evidence in relation to the five action points contained within the Improvement Notice IN000002, to establish if the Trust, Chief Executive, executive team and director of adult mental health & disability services had complied with the minimum standard in relation to the recognition and management of adverse incidents and near misses. We established the following in relation to each action:

Action Point 1

The Trust, Chief Executive, executive team and director of adult mental health & disability services must:

1. Undertake an urgent review of information recorded in the Trust's Datix system, to ensure that they understand the nature and extent of risks captured in the system as it operates across the Trust's directorate of adult mental health & disability services;

Representatives from the senior management team told us that additional staff had been employed to review historical incidents recorded on Datix to ensure all incidents had been accurately graded and to extrapolate themes and trends. However, whilst this work had begun, progress had been hampered by a lack of information contained in each Datix entry.

The initial findings were shared with the senior management team and used to inform training. We were told that following this training new entries on Datix were more comprehensive and complete.

Outcome of Action Point 1

We found that this action point had not been fully addressed and further improvement is required in relation to understanding the nature and extent of risks captured in Datix.

Action Point 2

The Trust, Chief Executive, executive team and director of adult mental health & disability services must:

2. Take appropriate action to identify and mitigate specific patient safety themes and/or trends identified as part of the above review and ensure these are appropriately addressed in a timely manner.

Representatives from the senior management team told us that they focused on delivering Datix training to staff so that going forward Datix entries would be sufficiently detailed to identify patient safety themes and trends. They also told us that they had held one meeting in relation to identifying trends. However, no minutes were retained to evidence topics discussed; subsequent action points or themes/trends identified and any subsequent learning.

Whilst there was some evidence of progress made in relation to the review of historical incidents, significant and timely progress has not been made in respect of the lookback exercise. We advised the senior management team that this piece of work was critical to enable them to understand and mitigate risks and encouraged them to progress this piece of work with a heightened degree of urgency and momentum.

Outcome of Action Point 2

We found that this action point had not been fully addressed and further improvement is required to identify and mitigate specific patient safety themes and/or trends.

Action Point 3

The Trust, Chief Executive, executive team and director of adult mental health & disability services must:

3. Assure themselves that staff across the directorate of adult mental health & disability services have sufficient knowledge, awareness and understanding of adverse incidents and near misses, so that they (incidents and/or near misses) are appropriately recognised and accurately recorded in the Trust's Datix system. The grading of adverse incidents and near misses must be based on the risk inherent in each event and not on the outcome reported for the event in question;

We reviewed Datix entries that had occurred since our last inspection 3-5 June 2019 and found a significant improvement in the quality of information recorded by staff who had completed the Datix training compared with entries made by staff who had not yet completed the Datix refresher training. We noted a number of staff have yet to complete Datix refresher training. We found evidence that incidents continued to be graded, based on outcome rather than the inherent risk. We also found that staff could not describe any learning from incidents yet when we discussed with staff we were able to identify missed opportunities for learning from two particular incidents. We also noted that a safeguarding referral was made two days following the original incident.

We remained concerned around; the timely reporting of and grading of incidents, identifying learning from incidents, the communication of incidents with all team members and a lack of mitigating action plans to address the risks inherent.

Outcome of Action Point 3

We found that this action point had not been fully addressed and further improvement is required in relation to the Trust being assured that staff have sufficient knowledge, awareness and understanding of adverse incidents and near misses so that they are appropriately recognised and accurately recorded in the Trust's Datix system.

Action Point 4

The Trust, Chief Executive, executive team and director of adult mental health & Ddsability services must:

4. Ensure that there are appropriate structures in place to review, approve, and escalate all incidents, adverse incidents and near misses captured in the Trust's Datix system as it operates across the directorate of adult mental health & disability services and demonstrate that mechanisms for assuring this dynamic process are sufficiently robust.

We reviewed the Trust's governance arrangements to review incidents. We met with nursing staff, deputy and ward managers and members of the senior management team. We were told that appointment of a ward manager (Band seven) in Carrick and an additional deputy ward manager (Band six) in Carrick, with responsibility for leading on incident management, has improved the management structures at ward level.

We were also told that Band six and seven staff had completed enhanced Datix training as they are Datix handlers and are responsible for approving Datix entries. The role of the Datix handler is to review each entry to ensure the incident is graded correctly and appropriate immediate learning has been identified. Once satisfied the handlers approve the entry.

Nursing staff told us that deputy and ward managers discuss incidents directly with them to highlight learning or request additional information if required. However, we identified some significant incidents and noted there was no records to evidence when or if incident debriefs occurred following a significant incident.

Overall there was a lack of assurance in relation to reporting incidents of a safeguarding nature, an example of this was when a safeguarding incident occurred between two patients, an incident form was completed for the alleged perpetrator only and not the victim.

There was little evidence of incidents that occurred at ward level, being shared amongst the ward team from shift to shift. For example, an incident in relation to adult safeguarding was not recorded on the daily ward safety brief but was discussed at the multidisciplinary team (MDT) safety brief. The immediate learning and potential safety issue was not discussed at ward level amongst the staff on shift therefore increasing the likelihood of reoccurrence.
The MDT safety brief appears to have been introduced in isolation from other safety briefs at ward level. There was limited evidence of risk from incidents being discussed at safety brief. The process for safety brief is dis-jointed with several safety briefs/huddles/ MDT huddles but no unified approach in relation to cascading of information to front line staff.

We met with operational managers, (Band eight A's) who told us they meet regularly with ward and deputy ward managers to review Datix entries and that they have dashboards to monitor Datix entries and ensure handlers are closing and approving entries. We were told that operational managers report directly to Head of Service (Band eight B).

We met with the governance lead for the directorate who informed us that they still assume responsibility for overseeing serious adverse incident (SAI) reviews and training new staff to undertake SAI reviews.

The governance lead and director of adult mental health and disability told us about a further development to enhance the governance structure around incident management; the implementation of an incident rapid review group. This group identifies and analyses trends and ensures appropriate action is taken to mitigate risks. They shared with us an example of this in practice.

We were also informed of an environmental health group (EHG) which is co-chaired by head of estates and the assistant director of adult mental health. This group focuses on how to reduce environmental risks, and considers the application and exploration of new technologies in mitigating risks.

We noted further work is required to align the operational and governance structures across the northern and southern sectors.

Outcome of Action Point 4

It is evident from our discussions with nursing and management staff that the Trust have strengthened structures to review, approve, and escalate all incidents, adverse incidents and near misses captured in the Trust's Datix system. Whilst we acknowledged the development of these new structures however, we determined that further time is required to embed these initiatives across the directorate of Adult Mental Health & Disability Services to demonstrate that mechanisms for assuring this dynamic process are sufficiently robust.

Action Point 5

The Trust, Chief Executive, Executive Team and Director of Adult Mental Health & Disability Services must:

Design and implement processes to ensure that i) they are regularly updated on the spectrum of adverse incidents and near misses occurring across the directorate of adult mental health & disability services, ii) all incidents and near misses are graded on inherent risk, iii) appropriate mitigating actions have been identified and progressed in relation to risks identified, iv) learning arising from incidents and near misses has been identified and shared with all relevant staff, and v) they and Trust Board receive appropriate assurance(s) regarding the operation of these processes.

Outcome of Action Point 5

From our review of the actions points one to four above, we are assured that the Trust have designed and implemented processes to ensure they are regularly updated on the spectrum of adverse incidents and near misses. However, as the new processes are in their infancy; a significant number of nursing staff still require Datix training; the review of the look back exercise is incomplete; and the identification of trends and themes for learning has not yet been appropriately captured we could not evidence that this action point had been fully addressed.

6.4 Conclusion of our assessment of the Trust's compliance with the Improvement Notice IN000002

We were unable to evidence that the five action points outlined in the Improvement Notice IN000002 had been fully addressed. The IN was therefore extended and must be complied with by 22 June 2020.

6.5 Other Inspection findings

6.5.1 Adult Safeguarding Training

As discussed in section 6.2 of this report, an area for improvement was made during the inspection on 3-5 June 2019 in relation to adult safeguarding. We found evidence that some progress with this area for improvement has been made. However, we also found evidence of delays in making safeguarding referrals and an incident that should have resulted in two safeguarding referrals and only one referral was made.

We reviewed mandatory safeguarding training records and found a notable difference between each sector's compliance rates. In Grangewood 10 out of 38 nursing staff required refresher training in child protection and 17 out of 38 nursing staff required refresher training in adult safeguarding.

In T & F 38 nursing staff had completed adult safeguarding training in accordance with the Trust's mandatory training programme, one staff member required child protection safeguarding training.

Ward managers told us that the Trust training on safeguarding does not incorporate the Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC) Safeguarding Adults Core Competency Framework which was launched in June 2019 for Nurses and Midwives.

We were informed senior members of the Trust management team were in negotiations with representatives from the Health and Social Care Board (HSCB) Clinical Education Centre (CEC) to deliver training which includes the NIPEC safeguarding framework.

The area for improvement in relation to adult safeguarding will be stated for the second time.

6.5.2 Environment: general environment; fire safety and ligature risks and environmental assurance mechanism

During our previous inspection 3-5 June 2019, we identified a number of serious concerns relating to the environment. Our concerns were categorised into three main areas; the general environment; fire safety and ligature risks and environmental assurance.

General Environment

Elm and Lime

We undertook a tour of the wards during this inspection and noted that significant progress had been made in relation to the general environment of Elm and Lime. We found:

- a process of de-cluttering had occurred;
- the walls were re-plastered and re-painted;
- damaged ceiling tiles were replaced;
- light fittings had been cleared of debris and cleaned; and
- the outdoor spaces had a general tidy up.

However, we observed that the curtains and privacy screens surrounding patient's beds were damaged and torn and had not been repaired or replaced. When we asked for a cleaning schedule for the curtains and privacy screens, none was available and staff could not recall or establish when these had been cleaned.

We noted the following issues with the environment;

- some windows (observation room) had no dressings or curtains;
- one sofa had a rip in its armrest;
- a number of internal and external windows/doors were boarded up; and
- there was no shelter for patients from the wind, rain or sun in the smoking area.

In relation to accessing the PICU, the front entrance to this ward is controlled by an airlock holding area. This means while the front doors are open no one can move into the ward until the front doors are closed. This safety mechanism also applies if one leaves the ward via the front entrance. However, the internal doors linking PICU to Elm and Lime wards do not have the same level of security and link doors could be forced open if sufficient force was applied.

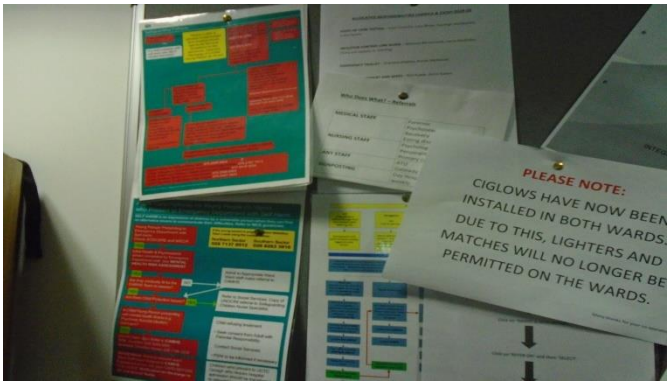
Carrick and Evish

We identified issues on Evish in relation to the environment that was not in keeping with best practice. Both toilets in the corridor of the ward were locked and on enquiry, we were informed that a few days prior to the inspection a patient had locked themselves in the toilet and an incident of self-harm had occurred. This was discussed with staff and the toilets were unlocked for patient use. The disabled toilet in the ward was also locked as this was being used as a storage area to store several items for example a pressure mattress and weighing scales. These issues identified were discussed with the ward manager who agreed to address them.

Fire Safety and Ligature Risks

We noted that the Trust had installed flameless ignition points “Ciglows” in outdoor spaces of each ward. Posters informing patients and relatives were placed in prominent positions outside and inside the wards reminding them that lighters were now a prohibited item. This was a welcome development following our previous findings in relation to a trend developing with regard to patients starting fires because they had access to ignition sources. All staff were familiar with the new policy.

In relation to the area for improvement with regard to the senior management team developing a local policy and procedure to manage and mitigate the risks associated with patients accessing ignition sources and ensuring the policy is shared with staff we assessed this area for improvement as met.



We spoke with nursing staff and found that they were not aware of the updated fire evacuation policy following the removal of the automatic door closures from bedrooms. We identified a fire safety issue, we observed that access to firefighting equipment was obstructed by a waste bin and other items. This was escalated and actions were taken immediately to resolve the issue.

We reviewed fire training records and found that 31 out of 49 staff member's fire training was out of date. We reviewed records of fire safety checks and found that checks and fire alarm tests were not consistently recorded. It was not clear who was responsible for completing routine fire safety checks in some parts of the building as it was a shared building with the day hospital and other office users.

We noted each ward only had four members of staff trained as fire wardens. We asked if there was a fire warden scheduled on each shift. We were informed that this was not always possible.

We immediately escalated and discussed these serious safety matters with the director of adult mental health and disability services at the end of the inspection to ensure immediate action was taken.

During subsequent correspondence, we received evidence confirming that;

- the fire risk assessment for Carrick and Evish was completed following the removal of automatic door closures;
- an update evacuation plan was completed; and
- staff had received updated fire evacuation training in light of these changes.

We were informed that the newly appointed ward manager had shown us an old fire training record and was not aware of where the most up to date fire training records were held.

We were also informed that a schedule of works to enhance the therapeutic environment in terms of outdoor space and to enhance privacy for patients when using the occupational therapy rooms is planned and due to be completed before the financial year end March 2020.

This area for improvement made in relation to the environment will be stated for a second time

6.5.3 Organisational Governance

We met with the directorate governance lead who confirmed that the senior management team have implemented and strengthened the governance structures within the directorate. We were informed that;

- two new posts have been approved to support the directorate's governance team and job descriptions are being drawn up;
- the directorate have reviewed their meeting structures and have now combined the senior management team meeting with the clinical social care governance meeting;
- the assurance structure for reviewing adverse incidents has been reviewed; and
- incidents that meet the threshold for the HSCB Procedure for the Reporting and Follow up of Serious Adverse Incidents, November 2016, follow a new assurance structure. Handlers approve the Datix entry, operational managers and the Head of Service are the second and third step in reviewing the incidents, which then proceed to the senior management and clinical social care governance meeting and finally are reviewed by the director.

In addition, we were informed, there is now a more comprehensive multi-disciplinary composition of members on the SAI panel including medical directors, consultant psychiatrists, occupational therapists, nurses and social workers. We were also informed that;

- a consultant by experience (a previous service user) is joining the SAI Panel (this is a new post);
- within the adult mental health & disability directorate there are 33 professionals trained in completing root cause analysis(RCA), an approved methodology for reviewing adverse incidents;
- across the directorate a further 30 people will be trained as Datix handlers; and
- the business service manager for the directorate now supports the governance framework.

We noted significant progress has been made in the directorate to review the governance structures however further work is required to align the northern and southern sectors.

The area for improvement regarding organisational governance will be stated for a second time.

6.5.4 Fluid Management and Physical Healthcare Needs

During the previous inspection (3-5 June 2019), in both sectors, we were concerned about the management of patients with hyponatraemia (a low sodium concentration in the blood). Although regular blood monitoring was undertaken and medical staff were reviewing the patients regularly, there was no management of fluid intake as fluid balance recording was not taking place.

We reviewed care documentation and noted in the T &F hospital one patient who remained on daily fluid balance charts. There was evidence that these charts were documented daily, and that fluid intake was being recorded. This was a notable improvement from the previous inspection.

In Grangewood, we identified patients who were not eating or drinking. We reviewed nursing records and identified significant issues relating to the management of fluids for a number of patients who were at risk of malnutrition and dehydration. We found no evidence of the recording or accurate oversight/management of the total fluid intake and output of each patient for each 24-hour period of care.

In some of these cases, the staff indicated that the treatment plan had not been updated as the patient's physical health had improved, therefore they did not currently require a fluid balance chart. In other cases, the patient's physical health remained a concern, but the patient was declining observation, so fluid balance charts were not kept or were sparsely recorded, with no documented evidence of the patient's refusal or of them having a regular review.

In addition to this, there was a separate "food and fluid" chart which recorded meals and drinks taken and offered, but rarely included quantities of food or fluid. There was also evidence of duplication of documentation for fluid intake.

Staff told us they had not attended formal training on hyponatraemia. However, an email was circulated to nurses that provided a link to an e-learning platform on hyponatraemia but there was no record maintained of how many staff had completed this training. We were informed that the Trust nurse development lead is sourcing training through the CEC to address training needs.

During our review of staff minutes and in our discussions with nursing staff, we found some evidence that physical health care awareness was discussed at team meetings. However, we found no evidence that training sessions for staff on physical health care was raised in any other forums. We were told that there had been some enhancement of the Band three health care assistant role with some staff having received training in National Early Warning Scale (NEWS) 2. This is a system for scoring the physiological measurements that can detect and respond to clinical deterioration and is a key element of patient safety

We reviewed the nursing records in Grangewood, found that treatment plans were difficult to access, and often poorly documented. We identified that;

- some of the nursing assessments and care plans were not complete in relation to the patients's physical health care needs;
- there was no evidence that a Malnutrition Universal Screening Tool (MUST) tool and Braden Score (A tool used to predict the risk of sustaining an pressure ulcer) had been completed;
- a patient with a visual impairment did not have a care plan in place;

- some care plans were generic and lacked detail to enable staff to care for the patient safely;
- care plans were not person centred and it was not clear if nursing interventions and care plans were discussed with the patient, to gain their consent;
- the person making the entry had not signed some of the entries in the care records; and
- some of the daily evaluation records were not contemporaneous and did not evidence the care delivered.

The charge nurse of the ward agreed that there were issues that needed to be addressed in relation to the recording of patient care to ensure that the records reflect the care being delivered.

During the serious concerns meeting on 20 December 2019 representatives from the senior management team informed us that the nursing governance team have been addressing issues around patients' physical health care needs and have progressed work in relation to care plans and audits. However, this work is in its infancy and will require further time to complete a full range of audits.

The area for improvement in relation to patient's physical health care will be stated for the second time.

6.5.5 Psychiatric Intensive Care Unit (PICU) Operating Model

During the previous inspection, we had serious concerns about the flexible PICU model in operation within the Trust and recommended the senior management team complete a review of the current model as it does not meet the national standards for PICU in terms of staffing or the physical environment, on either site.

During this inspection, we found evidence that the PICU was used inappropriately. We found that patients who were appropriate for a PICU setting, were mixed with patients placed in PICU to allow closer observation of their physical health. This is not an appropriate function of a PICU. The patient mix in the PICU could leave patients who are inappropriately placed vulnerable, and also leave them subject to restrictions that are not proportionate to their healthcare needs and could infringe on their human rights.

We confirmed that 16 patients were accommodated on Evish, three of these patients were nursed in PICU. Staff told us these patients were being nursed because there was greater staff availability in PICU to monitor their health care needs.

We were also informed that two staff members staffed the PICU during the day and this did not always include a registered staff nurse. We found evidence that this staffing arrangement was having an impact on the staffing levels in the remainder of the ward.

We found evidence on both sites of patients placed in the PICU setting for months, and in one example, up to two years. The National PICU guidelines recommend that PICU stay should not aim to exceed eight weeks. We found in these examples that staff accepted these patients were unsuitable for PICU, but despite a significant effort on behalf of the Trust they had been unable to identify more appropriate placements.

We were informed that the patients nursed in the PICU were not permitted to attend the day hospital activities and the occupational therapists also did not visit these patients. Staff confirmed that this arrangement is currently under review and a new occupational therapist is being recruited to work on the ward in the future.

We invited the senior management team to a serious concerns meeting on 20 December 2019 to discuss our concerns about the flexible PICU model in operation. We were informed that the review of the flexible PICU model had commenced but due to unforeseen circumstances was delayed in its progression. However, a renewed focus and energy has been committed to redefining the model used across the two sites. At this meeting, it was agreed that the service on offer does not meet the definition of a PICU and is more in line with an enhanced care model. The Trust agreed to submit a timeline for completion of a review of this service. This will include a clear vision of the service with a statement of purpose and operational guidelines.

The area for improvement in relation to the PICU operating model will be stated for a second time.

6.5.6 Infection Prevention and Control (IPC)

The IPC issues identified during the previous inspection 3-5June 2019 were not fully assessed during this inspection however during our tour of the wards we noted that a sofa was observed in the day room of Evish PICU to be overturned and was not available for use. On enquiry, we were told that the sofa had been contaminated with body fluids and there were no staff currently available to clean this effectively. We also noted a partially filled clinical waste bag had been left lying on the floor in a patient's bedroom, the waste bin in the office was observed to be blocked by other pieces of equipment making it difficult for staff to access. The issues identified were discussed with the ward manager and addressed during the inspection.

The area for improvement in relation to infection prevention and control was not reviewed during this inspection and will be carried forward for review at the next inspection.

6.6 Patient and staff views

In Grangewood, we were informed by patients that there was a lack of activities within the hospital. Staff confirmed that occupational therapists do not currently attend the ward and should patients request to attend activities these are only accessible in the day hospital. Some patients were concerned that they were unable to attend activities held in the day hospital as outpatients were given priority and there were no places available for inpatients to attend.

Several staff in Evish told us they had concerns regarding the staffing levels in the ward especially on days when patients were being accompanied to electro-convulsive therapy (ECT) treatments held in the main hospital or on ward round days. We spoke to patients who were mainly complimentary of the quality of care and services received however, we were informed by several patients that there was not enough staff on the ward to talk to and attend to their needs. We did observe staff engaging positively with patients and communicating effectively during patient care.

Patients who spoke with us confirmed that they were aware how to raise concerns however, a copy of the complaints procedure was not available in the ward for patients/and or their representatives. We discussed this with the ward manager and whilst information regarding the complaints procedure was available in the nurse's office, it was recommended that this information was available on the ward for patients and/or their representatives.

Across both sites, ten patients submitted responses to RQIA questionnaires. Each patient indicated they felt their care was effective, that they were treated with compassion and that the service was well led. Seven patients responded that they felt their care was safe. Three patients did not feel safe and stated this was due to them having to share dormitories and the behaviour of other patients who were unwell/ newly admitted.

One staff submitted a questionnaire response to RQIA. They indicated that they felt patient care was safe, effective, that patients were treated with compassion and that the service was well led.

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 chief executive, the director of adult mental health and disability services, and the divisional clinical director of psychiatry as part of the inspection process. The timescales for implementation of these improvements commence from the date of this inspection.

7.1 Areas for improvement

There were no new areas for improvement identified during this inspection. The attached QIP contains the areas for improvement carried forward from the last inspections of Carrick and Evish on 13 March 2019, Elm and Lime on 24 – 25 October 2017 and Carrick Evish, Elm and Lime 3-5 June 2019. The sixteen areas for improvement will be reviewed at a subsequent inspection.

Areas for improvement have been identified and action is required to ensure compliance with The Mental Health (Northern Ireland) Order 1986 and The Quality Standards for Health and Social Care DHSSPSNI (March 2006).

The senior management team 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 senior management team to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

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 **21 September 2020.**

Quality Improvement Plan

Action is required to ensure compliance with The Quality Standards for Health and Social Care DoH (March 2006)

Risk Assessments

Area for Improvement 1 **Ref**: Standard 5.3.1 (a) **Stated:** Second time **To be completed by:** 7 November 2019	The senior management team 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 Trust Senior Management team ensures that comprehensive risk assessments, completed by other mental health services are received prior to patients admission to the admission wards. Senior Trust managers attend the regional bed management meetings were this protocol has been discussed and agreed. The bed manager adheres to the WHSCT bed management flow chart that guides them to the safe transfer of relevant information that pertains to the patient. These are maintained and updated while the patient remains on the ward. We continue to endeavour to obtain patient notes in an acceptable timeframe before their admission to our wards.

Nurse Training on Psychological Formulation

Area for Improvement 2 **Ref**: Standard 4.3 (m) **Stated:** First time **To be completed by:** 7 November 2019	The senior management team shall develop a training programme to ensure staff have the skills and knowledge to complete care plans which are based on psychological formulations. **Ref: 6.2**
	Response by the Trust detailing the actions taken: The Trust senior management team have employed two psychologists 8B and 8C . We have provisional start dates of 5th October 2020. These professionals will lead on the development of knowledge and skills regarding psychological formulations and interventions across the multidisciplinary team.

Staffing Mandatory Training	
Area for improvement 3 **Ref**: Standard 5.3.1 **Stated:** First time **To be completed by:** 7 November 2019	The senior management team shall develop an action plan to address deficits in staff mandatory training. **Ref: 6.2**
	Response by the Trust detailing the actions taken: The Trust senior management team have developed a training matrix which captures mandatory training needs for all staff. This has been developed for both hospital sites. The Nursing support officer oversees this and populates when training is complete and alerts staff and ward managers when training is due.
Adult safeguarding	
Area for improvement 4 **Ref**: Standard 5.3.1 **Stated:** Second time **To be completed by:** 14 March 2020	The senior management team shall develop an action plan to address deficits in staff adult safeguarding training. The action plan shall also include the development and implementation of a rolling audit programme that provides the Trust with an assurance mechanism that all staff are competent and are adhering to the Trust's regional safeguarding policies. **Ref: 6.5.1**
	Response by the Trust detailing the actions taken: The Trust Senior Management team have developed a robust training programme that addresses the deficits in staff adult safeguarding training. This is a rolling programme that staff complete every three years. The Trust has completed a safeguarding audit and plan to continue this as a rolling programme also . We have adapted our Datix database to capture information on Adult safeguarding that will inform the audit process. Our Handover documentation also captures Safeguarding Information.

Management of ligature incidents and risk	
Area for improvement 5 **Ref**: Standard 5.3.1 **Stated:** First time **To be completed by:** 7 November 2019	The senior management team should review the ligature risk assessments for each ward and ensure that any action plans generated as a result of the risk assessments are actioned in a timely manner. The environmental ligature risk assessment should be a live document and not solely conducted on an annual basis. Areas identified for action must be regularly reviewed and should be updated when they are completed. **Ref: 6.2**
	Response by the Trust detailing the actions taken: The Senior members of the Trust review the ligature risk assessment for each ward and ensure action plans generated as a result of the risk assessments are actioned in a timely manner. The environmental ligature risk assessment is a live document and is updated when required. Areas identified for action are regularly reviewed and are updated when they are completed.
Management of Medicines	
Area for improvement 6 **Ref**: Standard 5.3.1 **Stated:** First time **To be completed by:** 7 November 2019	The Trust senior management shall address the following issues in relation to medicine management; • ensure there is a robust system in place with regard to stock control of medicines; • there are no expired medicines or medicine prescribed to patients that have been discharged retained in ward stock; • all discontinued or unwanted ward/patient medicines should be returned to the pharmacy/patient as applicable and in a timely manner; • ensure stocks of the same medicine are stored in the same place in the stock cupboards; • ensure all medicines are stored in their original packaging or pharmacy containers; • ensure a copy of the record for the disposal of medicines, sent to the hospital pharmacy, is retained on the ward; and • should review and consider enhancing pharmacy support in both hospitals. **Ref: 6.2**
	Response by the Trust detailing the actions taken: The Trust senior management team has addressed the issues as listed above in relation to medicine management. There is a proposal recently developed regarding enhancement of pharmacy support accross the in-patient wards.

Resuscitation and management of medical emergencies	
Area for improvement 7 **Ref**: Standard 5.3.1 **Stated:** First time	The Trust resuscitation officers should audit access to resuscitation trolleys across all wards and ensure that all relevant staff can assess this equipment in an emergency. **Ref: 6.2**
To be completed by: 7 July 2019	**Response by the Trust detailing the actions taken:** There is a daily check of the defibrillation and suction equipment on each resuscitation trolley. There are monthly checks of the whole trolley. If the trolley is used or seal broken, there is a full reset check by the trust resuscitation team. There is an annual audit of the trolley and checks as above by the trust resuscitation team. The trolleys are more physically available on each ward for staff to access in an emergency. The improvement works in T&F wards is ongoing and will further improve physical access to the trolleys.

Infection Prevention Control	
Area for improvement 8 **Ref**: Standard 5.3.1 (f) **Stated:** First time **To be completed by:** 7 July 2019	The Trust shall address the following matters in relation to infection prevention and control: • improve the standard of ward cleanliness; paying particular attention to ward sanitary wear and equipment storage areas; • commence a programme of decluttering and reorganisation of storage areas; • take action and provide assurance that staff are managing linen and waste in line with the Trust's policy; • improve the cleaning and organisation of domestic cleaning equipment and stores. Robust monitoring of these areas should be in place to provide continued assurance; and • take action to improve staff adherence to the Trust's policies on hand hygiene, use of personal protective equipment and uniform and dress. Robust monitoring should be in place to provide continued assurance. **Ref: 6.2**
	Response by the Trust detailing the actions taken: The Trust has improved the standard of ward cleanliness paying particular attention to ward sanitary wear and equipment storage areas. Sanitary bags has been sourced to improve safe disposal of sanitary products. The wards have decluttered and reorganised storage areas. The Trust has taken action and can provide assurances that staff are managing linen and waste in line with the trust policy. We have improved the cleaning and organisation of domestic cleaning equipment and stores monitoring of these areas are in place. The Trust has improved staff adherence to the Trust's policies on hand hygiene PPE, uniform and dress

Environment	
Area for improvement 9 **Ref**: Standards 4.3 and 5.3.1 **Stated:** Second time **To be completed by:** 31 March 2020	In respect of T&F the Trust shall address the following matters in relation to the environment: • undertake a survey of the interior fabric of the wards and generate an action plan to repair or replace any issues identified. Particular attention should be paid to floors; walls; lightening and ceilings; review the water safety/legionella risk assessment for the facility and implement any recommended improvements/control measures to reduce the potential risk of legionella bacteria in the water system; • submit to RQIA a suitable and sufficient fire risk assessment for the wards, any recommended action plan items must be noted with a completion date. RQIA must be informed of the completion or delay of any works action plan items, as works proceed; • ensure that oxygen cylinders are stored away from direct sunlight and undertake a risk assessment regarding the exterior glass door in the clinical room of Lime; • ensure the environment and furniture in the psychiatric intensive care unit (PICU) shared between Elm and Lime meet the required safety standard for a PICU; paying particular attention to glazing; install a clinical hand washing basin in the clinical room of PICU; and • remedial works should be undertaken to ensure a therapeutic outdoor environment for patients. In respect of Grangewood the Trust shall submit the following documentation to RQIA upon return of this quality improvement plan (QIP): • an updated fire risk assessment, an action plan generated as a result of this risk assessment. A progress report detailing the actions taken to address actions identified in the action plan to include timeframes; and • an updated risk assessment and water hygiene survey report following 11 October 2019 assessment. **Ref 6.5.2**
	Response by the Trust detailing the actions taken: The T&F have undertaken substantial refurbishment of Elm ward and PICU. Lime is currently in the process of phase three of these works. These works had been delayed because of Covid-19. All remedial works have been addressed. The trust has reviewed the water safety/Legionella risk assessment for the facility and improvements has been implemented. A fire risk assessment has been completed and will be submitted to RQIA. The oxygen cyclinder are stored away from direct sunlight. The exterior glass door in clinical room in Lime has now been removed as part of phase three of the current works.

	All furniture in the PICU has been updated to meet the required safety standards for PICU. All glazing in PICU has been replaced as part of phase one remedial works. T&F no longer has a clinical room in PICU. Remedial works have been undertaken to ensure a therapeutic oudoor environment for patients.
Management of Patient's Property and Finances	
Area for Improvement 10 **Ref**: Standard 5.3.1 **Stated:** First time **To be completed by:** 7 November 2019	The Trust shall ensure that all relevant staff are familiar with the policy and procedure for securing and managing patient's property and finances with particular regard to; • recording patient items against the correct patient; • accurate entries are made in patient finance records; and adherence to the policy and procedure for amending errors. The Trust shall: • update and complete regular financial audits at ward level to assure themselves that the Trust's policy in relation to the Management of Patient's Property and Finances is being adhered to; and • ensure the audit identifies when and who areas of concern should be escalated to, if applicable. **Ref: 6.2**
	Response by the Trust detailing the actions taken: The Trust ensures that all relevant staff are familiar with the policy and procedure for securing and managing patient property and finances. The ward managers will undertake monthly financial and property audits, commencing September 2020. Areas of concern will be escalated to the Service Managers and trust finance department.

Physical Health Care	
Area for improvement 11 **Ref**: Standard 5.3.3 **Stated:** Second time **To be completed by:** 14 March 2020	The Trust shall address the following matters in relation to physical health care needs: • undertake a review of specialist consultant input for patients with an eating disorder; and • review the system for monitoring patients who are subject to fluid restriction to ensure that all patients with hyponatraemia are being managed in accordance with NICE Clinical Guidance CG174. **Ref: 6.5.4**
	Response by the Trust detailing the actions taken: The trust has secured funding for Consultant input to the Eating Disorder team on a sessional basis. This is being developed along with Mental health liaison services and other regional resources. The Trust has reviewed the system for monitoring patients who are subject to fluid restriction to ensure that all patients with hyponatraemia are being managed in accordance with NICE clinical guidance CG174. There is a rolling training program for staff that identifies and shows the management and treatment of patients with hyponatraemia. Physical health care is audited on a monthly basis at ward level and the Crisis service manager audits fluid management every two months. This is recorded on the Trust dash board.

Therapeutic Activity	
Area for improvement 12 **Ref**: Standards 5.3.3 6.3.1 6.3.2 **Stated:** First time **To be completed by:** 7 November 2019	The Trust shall review and enhance patient engagement in relation to therapeutic activities and patient engagement with particular regard to: (a) reviewing the provision of therapeutic activities; to include evenings, weekends and bank holidays. The review should consider the type of activities and how and where it is delivered; (b) ensure the results of patient experience questionnaires are shared with staff. An action plan should be generated to improve service delivery; and (c) ensure that patient experience feedback is considered, measure, monitored and informs pieces of quality improvement work. (a) Ward managers should ensure patient/staff meetings occur on a regular and consistent basis. The minutes of meetings should refer back to items discussed at the previous meeting and note any follow-up taken to address issues discussed. **Ref: 6.2**
	Response by the Trust detailing the actions taken: The Trust will endeavour to provide therapeutic activities and encourage patient engagement through individual therapeutic planners to include weekends/evening and bank holidays. The Trust service user experience consultant has co-produced a patient experience questionnaire that captures feedback from patients which is considered, measured and monitored and will inform quality improvement. This was commenced on the 01/09/2020. Findings will be shared at staff meetings and at governance meetings. Ward managers ensure that patient/staff meetings occur on a weekly basis. Actions from previous meetings are captured and discussed. This is evidenced through the minutes of each meeting.

Organisational Governance	
Area for improvement 13 **Ref**: Standard 4.3 **Stated:** Second time **To be completed by:** 14 July 2020	The Trust shall address the following matters with respect to the governance arrangements across the adult mental health and disability directorate: • undertake a rapid review of the Trusts governance structures to determine what committees/forums and meetings are required in order to assure best practice; • the role and responsibilities of each committee need to be clearly delineated to ensure there is no ambiguity with respect to who has overall responsibility for clinical governance, operational management and any other relevant roles within the directorate. All roles need to be clearly defined and specified; • governance structures within the directorate should be shared with staff; and • Grangewood and T&F governance structures should be closely aligned to ensure equity in relation to patient flow and care pathways; and that quality improvement initiatives are integrated across the directorate.
	Response by the Trust detailing the actions taken: The trust Mental Health and Disability Directorate Governance structures have been reviewed and a proposal established and submitted for funding approval. This includes: • Band 8C Assistant Director Governance Nurse Lead • Band 8C Assistant Director Governance Social Work Lead • 3 x Band 8a Governance Lead, including service improvement Recurrent funding for 2 x 8a governance posts is already established. In mid July, the Trust submitted Mental Health Demography IPT to secure permanent funding for the 2 x 8c and 1 x 8a posts. The Directorate has also been re-configured to improve Operational management and lines of accountabilty, with a single Assistant Director/Divisional Clinical Director now responsible for In-patient and Crisis Services, with an aligned single head of Service(8b) and Service Managers (8a) on each site. The Business team has been developed with recruitment of a Reform and Modernisation Manager and a Systems manager. They are able to support the governance arrangements of the Directorate as required. The following Committees / forums / meetings support the governance agenda: • Trust Governance meeting • Rapid Review Group • Monthly Directorate governance meeting • Divisional governance meetings – across Learning Disability, Mental Health and Physical and Sensory Disability

PICU Operating Model	
Area for improvement 14 **Ref**: Standard 4.3 **Stated:** Second time **To be completed by:** 14 July 2020	The Trust shall review the arrangements in respect of the psychiatric intensive care units (PICUs). The review should consider the NAPICU, National Minimum Standards for Psychiatric Intensive Care Adult Service, (September, 2014) and include: • bed occupancy, patient need, staffing, levels of observation and ability to respond to emergencies and out of hours admissions; • identification of normative nursing staffing levels for each inpatient ward to include nursing capacity to undertake joint medical and nursing assessments for admissions; and • a review of the E-rostering system ensuring that bank shifts are easily identified and the system is user friendly. **Ref:6.5.5**
	Response by the Trust detailing the actions taken: Following subsequent inspections RQIA requested "The trust will undertake a review of the current flexible model of care in PICU which will address the core question of whether the current model is the most appropriate model for PICU provision in the trust going forward; • The trust will include independent expertise in the panel who will undertake the above review (two independent experts); and • This review will take account of the needs of the population across the Trust and will be fully completed by July 2020." This timeline has been challenged by Covid pressures, and an extension approved by RQIA. The prelminary (virtual) meeting of the trust senior managers with the 2 identified independent experts is 04/09/2020. The e-roster system has been reviewed and easily identifies bank shifts. It is user friendly. The bank list has been recently validated and updated.

Audits	
Area for improvement 15 **Ref**: Standard 4.3 **Stated:** First time **To be completed by:** 7 November 2019	The Trust shall address the following matters with respect to audits: • undertake a review of the rolling audit programme to ensure it provides the Trust with the necessary assurances in relation to the standard of care; • undertake a review of audit tools to ensure they are user friendly and in accordance with best practice guidance and evidence base; • ensure a consistent approach to audits is undertaken across the northern and southern areas within the directorate; • ensure that robust arrangements are established to escalate issues identified during the audit process through the directorates governance structures; and • consideration must be given to how audit findings are analysed for trends/comparative data, and how audit findings are shared with relevant governance committees; staff and patients. **Ref: 6.2**
	Response by the Trust detailing the actions taken: The Trust has addressed the following matters with the respect to audits. Both service managers have met with lead nurse for Governance and reviewed and updated the audit schedule and audit tools to ensure a robust audit process which is user friendly and inaccordance with best practice guidance and evidence base. Both service managers work in partnership to ensure a consistent approach which involves validating the audits in Northern and Southern areas within the directorate. The service managers lead on monthly team health checks and produce trend analysis/comparative data which is displayed on each ward. This is desiminated to ward teams through their staff meetings. This is also shared with senior managers through governance meetings. Mental health inpatient wards across the Northern and Southern sector has adapted a new process (ALAMAC) which provides the teams with the opportunity to collect data. This data includes staffing levels,sickness/attendance/incidents/ patient behaviors etc. This information will inform practice moving forward and provides us with an evidence base.

Please ensure this document is completed in full and returned via email to BSU.Admin@rqia.org.uk

Name of person (s) completing the QIP			
Signature of person (s) completing the QIP		**Date completed**	
Name of responsible person approving the QIP			
Signature of responsible person approving the QIP		**Date approved**	
Name of RQIA inspector assessing response	**Carmel Treacy**		
Signature of RQIA inspector assessing response	**Carmel Treacy**	**Date approved**	**21/09/20**

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