The Regulation and Quality Improvement Authority

Inspection Report

29 March - 12 April 2021

Western Health & Social Care Trust

Carrick and Evish
Grangewood Hospital
Gransha Park
Clooney Road
Londonderry
BT47 6TF
Tel No: 028 7186 0261 & 028 7186 4379

Elm and Lime
Tyrone and Fermanagh Hospital
1 Donaghanie Road
Omagh
BT79 0NS
Tel No: 028 8283 3100 & 028 8283 5368

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Assurance, Challenge and Improvement in Health and Social Care

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1.0 Service information

Organisation/Registered Provider: Western Health and Social Care Trust	**Responsible Person:** Dr Anne Kilgallen, Chief Executive Officer Western Health and Social Care Trust (WHSCT)
Person in charge at the time of inspection: Ms. Karen O' Brien, Director of Adult Mental Health and Disability Services.	**Number of commissioned beds:** Carrick: 15; Evish: 15; Elm: 13; Lime: 13
Categories of care: Mental Health Learning Disability (MHLD) Acute Admission	**Number of beds occupied in the wards on the day of this inspection:** Carrick: 14; Evish: 16; Elm: 13; Lime: 13

Brief description of the accommodation/how the service operates:

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

Carrick is a male ward and Evish is a female ward, both situated in Grangewood Hospital, Londonderry (Northern Sector). Both wards consist entirely of single occupancy ensuite side rooms. Additionally, both wards have access to six Psychiatric Intensive Care Unit (PICU) beds.

Elm is a female ward and Lime a male ward, both situated within Tyrone and Fermanagh (T&F) Hospital, Omagh (Southern Sector). Both wards consist of a mix of single occupancy rooms and multi-patient dorms. There is an adjoining Psychiatric Intensive Care Unit (PICU) between both wards that can accommodate up to four patients.

2.0 Inspection summary

An unannounced inspection to the MHLD acute admission wards across the Trust commenced on Monday 29 March 2021 at 9:00am and concluded on Monday 12 April 2021 with feedback to the senior management team.

The inspection was carried out by a combination of care and pharmacy inspectors with input from RQIA's Clinical Lead.

This inspection forms part of a series of inspections to the acute mental health inpatient services across all five Health and Social Care (HSC) Trusts in Northern Ireland. These inspections are being undertaken following our review of information and intelligence, highlighting significant pressures across three HSC Trusts as a result of ongoing bed pressures in acute mental health inpatient services in Northern Ireland. Best practice guidelines recommend that bed occupancy should be at 85%. At present demand for acute mental health inpatient beds in Northern Ireland has increased significantly and occupancy levels have escalated to over 100%. On occasions there have been no commissioned beds reported as being available across Northern Ireland, leading to decisions to admit patients to contingency beds or in some cases to support patients to sleep on settees or chairs until such times as a bed becomes available. This series of inspections aims to identify whether over occupancy is impacting the safe delivery of patient care and treatment. This series of inspections also aims to share good practice between Trusts to manage over occupancy and to support regional wide improvements.

This inspection focused on eleven key themes: patient flow; environment; restrictive practices; management of incidents/accidents/adult safeguarding; patient comfort; care and treatment; staffing; medicines management; governance and leadership; patient engagement; and staff engagement. Each theme was assessed by inspectors to determine if over occupancy was affecting the delivery of safe care. Additionally, any areas for improvement identified during or since the last inspection that directly impacted over occupancy were reviewed.

This inspection identified that the Trust's acute mental health inpatient wards were frequently over occupied. We determined that the over occupancy had a minimal impact on the ability of staff to deliver safe care to patients.

Central to the successful management of over occupancy in this Trust was their ability to utilise beds which were over and above their commissioned bed availability. The regional Health and Social Care Board commission 56 beds in this Trust for acute mental health inpatient provision. In response to Covid, social distancing and an ability to support Covid-19 screening the Trust reduced the number of commissioned beds in the footprint of Elm and Lime wards and repurposed Rathview Home Treatment House from a registered nursing home back to acute care provision following approval by RQIA. In order to support acutely unwell patients to be admitted to the service the Trust are using the available beds within Elm and Lime wards and the additional six beds available following the repurposing of the Rathview as an inpatient unit. The Trust is operating at ten beds over and above their commissioned bed numbers on an almost continual basis. We discussed the importance of ensuring regional commissioners are informed of the additional non-commissioned beds being used. This will ensure service provision across the region is planned in an equitable and informed way.

Senior Trust staff informed us that a lack of community facilities and resources to support patients who require care and treatment in a slow stream rehabilitation facility means that these patients are delayed in their discharge. There are approximately 10 patients in this category. An inability to discharge these patients to an appropriate facility in the community is impacting on the flow of patients across the acute mental health inpatient wards.

Strong governance and assurance, effective leadership, and clear communication mechanisms were other important factors in supporting the delivery of safe care at times when the service was over occupied. Staffing levels were safe and staff were routinely observed providing a high standard of care and treatment. Incidents and accidents including adult safeguarding (ASG) matters were managed well and in line with Trust policy and ward environments were clean, tidy and conducive to the delivery of care.

Patients told us they were treated with dignity and respect and felt that staff actively listened to them and attended their needs. Patients were observed being supported by compassionate staff who took all necessary steps to maintain their dignity, privacy and comfort at all times. All staff advised that they would be happy for a close family member to be cared within this service.

Effective leadership at ward and senior management level has enabled the Trust to deliver a safe and compassionate service whilst embedding a least restrictive approach to supporting people with mental illness**.**

A total of four areas for improvement were identified one of which has been stated for a second time. Areas that require improvement relate to bed management policies and data collection, the use of 'when required' medicines, reorganising of ward store rooms to allow for effective cleaning practices, the monitoring of the condition of patient mattresses and the completion of patient discharge letters in line with policy.

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. To do this, we gather and review the information we hold about the service, examine a variety of relevant records, meet and talk with staff and management and observe practices throughout the inspection.

The information obtained is then considered before a determination is made on whether the service is operating in accordance with the relevant legislation and quality standards.

Our reports reflect how they were performing at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the Responsible Person to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

4.0 What people told us about the service

Posters were placed throughout wards inviting patients and staff to complete an electronic questionnaire.

Four patients submitted responses. Patient responses indicated that they felt their care was safe and effective, that they were treated with compassion and that the service was well led. Sixteen interviews took place with patients who all indicated that they felt safe and were satisfied with each of these areas of their care.

There was no staff questionnaires returned however there were 17 staff interviews conducted. Staff responses indicated that they felt patient care was safe, effective, that patients were treated with compassion and that the service was well led. All staff indicated that they felt supported in their roles and that the senior management team were visible on wards and responsive.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

The last inspection to the Trust was undertaken on 29 June 2020. 10 areas for improvement were identified.

<table>
<tr><th colspan="3">Areas for improvement from the last inspection on 29 June 2020</th></tr>
<tr><th colspan="2">Action required to ensure compliance with The Mental Health (Northern Ireland) 1986 and The Quality Standards for Health and Social Care DHSSPSNI (March 2006).</th><th>Validation of compliance</th></tr>
<tr><td>Area for Improvement 1

Ref: Standard 5.3.1

Stated : First Time</td><td>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.</td><td rowspan="2">Met</td></tr>
<tr><td></td><td>Action taken as confirmed during the inspection:
The Ligature Risk Assessments had been reviewed by the Senior Management Team and all necessary actions taken with evidence of regular review.</td></tr>
</table>

Area for Improvement 2 **Ref:** Standard 5.3.1 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.	**Partially Met**
	Action taken as confirmed during the inspection: Improvements with standard infection control precautions, which included ward cleanliness, hand hygiene practices, use of PPE and the management of linen and waste were evident. Store rooms and rooms used by domestic staff remained cluttered and insufficient cleaning was evident in sanitary areas. There was limited evidence of the monitoring and assurance of practice in these areas. This area for improvement has been partially met. The relevant sections have been stated for the second time.	

Area for Improvement 3 **Ref:** Standards 4.3 and 5.3.1 **Stated :** Second 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, and action plan generated as a result of this risk assessment. A progress report detailing the actions taken to address issues identified in the action plan to include timeframes; and • an updated risk assessment and water hygiene survey report following 11 October 2019 assessment.	

	Action taken as confirmed during the inspection: There had been substantial refurbishment of Elm, Lime and the PICU. Remedial work had been undertaken to provide a therapeutic outdoor space for patients. Structural work had been carried out to improve the fabric and fittings within the wards, this included repurposing of rooms and investment in new furniture and flooring. It was established glazing had been replaced to meet the required safety standard. The room previously identified as the PICU clinical room was now being used as a store and therefore a clinical hand washing basin was no longer required. The oxygen cylinders were stored appropriately away from direct sunlight. The estates manager told us further remedial work scheduled had been delayed due to the impact of COVID-19. The Trust's Fire Risk Assessments and Water Safety Plan had been updated and actioned appropriately. The Trust's Estates Management told us that they will ensure fire and water safety controls are implemented at both sites.	**Met**
Area for Improvement 4 **Ref:** Standard 5.3.1 (a) **Stated:** Second time	The registered person shall ensure that 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.	**Met**
	Action taken as confirmed during the inspection: All new patients admitted to the wards had comprehensive risk assessments completed. A review of the risk assessments confirmed they were updated regularly and appropriately during the patient's admission reflecting changes in level of risk.	

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.	**Met**
	Action taken as confirmed during the inspection: The Trust have developed a training matrix which captures mandatory training needs for all staff on both hospital sites. The training matrix was available on the wards and details compliance with mandatory training. The training matrix highlights the number of staff whose training may be due or have lapsed. There was a good system of assurance in place and evidence that actions were being taken where required.	
Area for Improvement 6 **Ref:** Standard 5.3.1 **Stated:** Second time	The registered person shall ensure that 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.	**Met**
	Action taken as confirmed during the inspection: The training matrix evidenced compliance with adult safeguarding training across all wards. An audit of staff competency in relation to adult safeguarding procedures was reviewed which included confirmation that staff are adhering to the Trust's safeguarding policies in line with the regional policies. There were clear action plans in place to address any deficits.	

Area for Improvement 7 **Ref:** Standard 5.3.1 **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: Medicines were observed to be appropriately stored and stock control was well managed. Treatment rooms were tidy and organised. Medicines were observed to be removed in a timely manner once the expiry date had been reached. It was good to note that Pharmacist support has been enhanced in all wards since the last inspection and was having a positive impact on medicines management.	
Area for Improvement 8 **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.	**Met**
	Action taken as confirmed during the inspection: Trust resuscitation officers have reviewed access to emergency trolleys throughout wards and confirmed that they were easily located within treatment rooms and readily available for staff.	

<table>
<tr>
<td rowspan="2">Area for improvement 9

Ref: Standard 5.3.3

Stated: Second time

To be completed by:
14 March 2020</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</td>
<td rowspan="2">Met</td>
</tr>
<tr>
<td>Action taken as confirmed during the inspection:

The RQIA Clinical Lead confirmed that a review of specialist consultant input for patients with an eating disorder had been undertaken and actions had been taken to address any deficits is this service.

The Trust had reviewed the system for monitoring patients who are subject to fluid restriction and have undertaken an audit of recording charts relating to any patient requiring fluid restrictions. There was evidence of staff training on hyponatraemia and ongoing auditing of patient’s physical health care needs and fluid management.</td>
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</table>

Area for Improvement 10 **Ref**: Standard 5.1 Criteria 5.3.1 (f) **Stated:** First time	**The Western Health and Social Care Trust must ensure that:** 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 those quality improvement initiatives are integrated across the directorate.	**Met**
	Action taken as confirmed during the inspection: The Trust undertook a review of their governance structures, strengthened the leadership across the Directorate, improved the operational management and lines of accountability and streamlined the number of meetings and committees. There was evidence of good governance and connectivity between the relevant groups and structures which are now working more effectively.	

5.2 Inspection Finding

This inspection focused on eleven key themes. Each theme was assessed by inspectors to determine if over occupancy was having an impact on the delivery of safe care.

- Patient Flow
- Environment
- Restrictive practices
- Management of Incidents/Accidents/Adult Safeguarding
- Patient comfort – human rights, privacy and dignity
- Care and treatment
- Staffing
- Medicines management
- Governance and Leadership
- Patient engagement; and
- Staff engagement

5.2.1 Patient Flow

Patient flow is a core element of any service management process. The objective of patient flow is to enable patients to get to the right place so their care needs can be appropriately met. Good patient flow is dependent upon a number of factors, including; the delivery of a robust escalation policy, daily decision making, early escalation and the ability to respond to surges in demand, good communication and proactive management of admissions and discharges, robust and reliable information and early identification of patients expected date of discharge (EDD).

We reviewed these systems and processes to determine their effectiveness in managing the increased demands on these services.

The Trust is commissioned for 56 beds across its acute mental health inpatient services. It was evident on the days of the inspection that the Trust was operating over the recommended 85% acute bed occupancy recommended by The Royal College of Psychiatrists. This recommendation had been set as operating a service with high levels of bed occupancy may affect patient care, as directing patients to the bed most suitable for their care is less likely to be possible.

In an effort to increase bed capacity the Trust was making use of accommodation previously used as a home treatment area and registered with RQIA as a nursing home. On 11January 2021it was deregistered as a nursing home and repurposed as a six bedded acute mental health inpatient unit called Rathview. During the Covid-19 pandemic the Trust were using Rathview for Covid-19 screening and clearance before patients transferred to the acute mental health wards in Elm or Lime.

As a result of the increasing demands on the acute mental health system across the region the Trust have taken a decision to utilise additional beds to enable them to support acutely unwell patients and reduce the impact of over occupancy. Notably all patients had a physical bed space.

The Trust are operating at ten beds over and above their commissioned bed numbers on an almost continual basis. We discussed the importance of ensuring regional commissioners are informed of the additional non-commissioned beds being used. This will ensure service provision across the region is planned in an equitable and informed way.

Senior Trust staff informed us that a lack of community facilities and resources to support patients who require care and treatment in a slow stream rehabilitation facility means that patients are delayed in their discharge. There are approximately 10 patients in this category. An inability to discharge these patients to an appropriate facility in the community is impacting on the flow of patients across the acute mental health inpatient wards

The Regional Bed Management Protocol for Acute Psychiatric Beds (Aug 2019) is the regional guidance developed by the Social Care Commissioning Lead for acute mental health in collaboration with the five Trusts in Northern Ireland. It was developed to guide the Trusts in managing their acute mental health inpatient beds and support admission of patients to an appropriate facility to meet their individual needs in a timely manner. Staff were familiar with the protocol; however, there was limited evidence that the protocol was being fully embedded in practice.

Localised escalation policies had not been developed to support staff in managing bed pressures. A policy for patients on leave is required and should include guidance on how to manage the unexpected return of a patient from leave whose bed has been used for another patient. The development of these policies would provide clear operational guidance for the management of bed capacity to optimise patient safety and experience and availability of hospital beds to effectively manage surges in demand. An area for improvement has been made.

The recent recruitment of a Bed Capacity Network Coordinator to the acute mental health inpatient service has been positive in establishing a more co-ordinated and collaborative approach to patient flow both within the Trust area and across the region. This individual is responsible for coordinating all bed management plans which includes, the number of beds available, occupied beds, patients allocated on leave, patients supported on level of observations and patients that are identified for potential discharge. An important aspect of this role is the engagement through a regional network with other Trusts which supports the understanding and subsequent co-ordination of bed pressures across the region.

Discharge planning is discussed at MDT meetings. When the hospital is experiencing bed pressures the MDT identify patients who are close to discharge by using a traffic light system, green indicates those patients close to discharge and can be considered for early discharge based on clinical review. Staff told us during periods of bed pressures clinicians are requested to carry out additional ward rounds to assist in identifying patients who are suitable to continue their care outside the hospital for example at home with support from the Home Treatment Team. Information was provided which evidenced bed management issues were discussed at a variety of meetings attended by clinical and managerial staff. The Bed Capacity Network Coordinator receives bed status updates for the Trust twice daily, enabling up to date planning and reconfiguration of beds where needed. The information details the number of available beds, definite and potential discharges and expected admissions.

All patients should have an estimated discharge date (EDD) set on admission (as per Trust policy), reviewed daily and updated as required to provide an accurate indication of when each bed in the hospital will become available for use by another patient. Staff including managers told us that when EDDs were not agreed early in the patient's journey, this could lead to delays in discharge. While some patients did have an EDD recorded in their care records, this was inconsistently recorded and reviewed.

The Trust operate a number of IT systems to manage patient information including PARIS, ALAMAC and Open Ward. These systems were not being fully utilised to collate bed occupancy data. There was no information regarding category of admissions and length of stay being recorded. Review and analysis of this information is integral for optimising patient flow. An area for improvement has been made.

5.2.2 Environment

We visited each of the wards to review and assess if the environment was safe and conducive to the delivery of care.

Both Evish and Carrick wards in Grangewood Hospital are modern in design and equipped with single occupancy ensuite rooms. This contrasts to the layout of Elm and Lime, which are more traditional in style incorporating a number of four bedded bays and two single rooms, with a number of communal toilets and shower facilities. While the contrast in layout and design was evident staff were managing the subsequent challenges effectively.

A refurbishment programme was recently completed in Elm and Lime, with a number of rooms on each ward being reconfigured to provide additional quiet space for patients and to centralise the nurses' observation station. A painting programme had been undertaken to enhance the environment.

The PICU in all areas consisted of single rooms with a mix of gender assigned toilet and shower facilities.

The standard of environmental cleaning of clinical and non-clinical areas throughout wards was generally good although additional attention to detail in cleaning practices is required to the male ward sanitary areas. While ward bays and side rooms were tidy and uncluttered, store rooms including the domestic store were disorganised with stored equipment which prevented ease of cleaning.

A review of a selection of documentation including minutes of meetings; risk assessments; audits of the environment and staff Infection Prevention and Control (IPC) practices; and staff training records confirmed good governance measures in place to support staff and promote IPC in all of the wards. Covid-19 general risk assessments were completed and information to guide staff, patients and visitors on the Covid-19 measures to be taken was displayed in each area.

Staff were knowledgeable on IPC practices and good compliance with IPC practices was observed in relation to hand hygiene practices, equipment cleaning, use of PPE; and the management of linen and waste.

Ligature risk assessments were completed with evidence in all wards that actions had been taken to address any identified risks. Safety checks were being undertaken routinely to identify new or emerging ligature risks, or risks associated with patients bringing contraband or high risk items onto the wards. In one ward the safety check record had been enhanced to include a spot check of the environment for clutter and any issues with cleaning, this was considered an area of good practice which should be shared with other acute mental health inpatient units across the Trust.

A selection of patient mattresses were checked, a number of mattresses were found to be damaged or stained and not fit for purpose. A review of mattress audits identified that mattress audits were not carried out routinely. An area for improvement has been made.

We determined that over occupancy was not impacting the Trust's ability to provide an environment that was safe and conducive to the delivery of care.

5.2.3 Restrictive Practices

The management of Restrictive Practices across the four inpatient wards was reviewed to determine if over occupancy was having an impact on the use of restrictive practices.

Restrictive practices in use included locked doors; level of patient observations and physical intervention. We determined that restrictions which were in place had been risk assessed and were proportionate to the level of risk in keeping with best practice guidance.

Patient's care records reflected detailed recording and a plan of care for any restrictions. There was evidence that consideration had been given to the patient's human rights including deprivation of liberty safeguards. Any planned restriction was reviewed weekly by the patient's named nurse or sooner were the level of risk had increased. Change in the patients risk status lead to a review with the multi-disciplinary team (MDT) and there was evidence that the increasing risks were further assessed and individually managed. MDT meetings evidenced discussion around reducing restrictions through the use of unescorted leave, home leave and time of the ward.

Staff demonstrated a good awareness of restrictive practices. Staff told us that physical intervention was used as a last resort and de-escalation techniques are prioritised to support patients. It was evident that the leadership team across all of the wards promoted a least restrictive approach to care and the use of restrictive practices was low. A review of the monthly Team Health Checks evidenced good governance and oversight regarding the use of restrictions.

There was no association that over occupancy was having a detrimental effect on the use of restrictive practices.

5.2.4 Incidents/ Accidents and Adult Safeguarding Management

Incidents recorded on the Trust's electronic reporting system, Datix, from 01 January to 29 March 2021 were reviewed to determine if there was an increase in number or complexity of incidents as a result of over occupancy. From our review we determined that there was no direct correlation between the two.

We were assured through discussions with staff that incidents were as a result of specific patients' presentation and reflective of their mental illness.

Incidents were being well managed, recorded appropriately, risk assessed correctly and we could evidence that the improvements made previously by the Trust have been sustained. Senior managers had commenced a process of validation audits of incidents recorded which was proving beneficial in highlighting any trends or areas for improvement.

Senior management provided assurance of steps to address any deficits in training as a result of staff pressures during the Covid-19 pandemic. Examination of staff training records for reporting incidents identified some deficits in training however there was no evidence this was having a negative effect on the reporting of incidents.

Incident reports clearly demonstrated when a safeguarding referral was considered or made. Staff at the T & F site highlighted concerns regarding the limited feedback they receive from the adult safeguarding team when they make a referral. Currently the T & F site have reduced social worker resource. We were informed by the senior management team that two additional social workers had been recruited. It is hoped that this will strengthen the team and support better communication between social work and ward staff. In addition senior management advised that a staff member from the adult safeguarding team had been identified to link with the wards to provide support and oversight of safeguarding cases.

Staff demonstrated good knowledge of what constituted an adult safeguarding concern, the process of completing an adult safeguarding referral and that all safeguarding concerns are discussed with the MDT. Ward managers were identified as the adult safeguarding champions. All staff were adhering to the Adult Safeguarding: Prevention and Protection in Partnership Policy (2015). A review of all adult safeguarding referrals from 01 January – 29 March 2021 evidenced detailed recording with clear evidence of the safeguarding advice and protection plans. All staff training in relation to adult safeguarding was up to date.

There was evidence that ward safety briefs were meaningful tools and provided a brief overview of risks (both environmental and patient specific). We discussed the current tool and recommended enhancing it by adding a specific section for safeguarding. We were informed of a planned audit of the safety briefs and the senior management team were in agreement that the inspection findings would inform the audit.

Mechanisms to assure robust management of incidents, accidents and adult safeguarding were maintained and were not being adversely affected by over occupancy of the wards.

5.2.5 Patient Comfort

Patient care practices were observed to determine if patient comfort had been impacted by over occupancy.

At all times, staff were observed treating patients with kindness and respect whilst delivering care and treatment in a committed and compassionate manner. Staff responded to patients in a timely manner and in a way they understood. The absence of single occupancy bedrooms for patients within Elm and Lime wards and patients having to use communal bathrooms posed some obvious privacy challenges however staff made every effort to protect the dignity and privacy of all patients.

The Trust had purchased chairs that can be reclined into a bed; they were using these only in circumstances when all beds were occupied across the service.

It was positive to note that these chairs were located in individual quiet rooms to afford privacy and dignity for patients during time of over occupancy. An individual risk assessment is undertaken for each patient prior to use.

Patients were provided with the opportunity to select a meal of their choice from the hospital menu and staff advised that patients had access to snacks, tea and coffee throughout the day.

Patients were provided with information on admission which included advocacy services, meal times, property, the environment, discharge planning and how to make a complaint and consent. Additionally information for patients was clearly displayed throughout the ward.

Overall, staff were taking all necessary steps to maintain the dignity, privacy and comfort of patients when wards were operating over and above their commissioned beds.

5.2.6 Care and Treatment

Patient records were reviewed to determine if over occupancy was impacting on the care and treatment of patients.

Each patient had an admission assessment completed by a doctor and nurse in line with Trust policy and had comprehensive risk assessments completed and care plans in place to reflect their individual needs. The records contained the patients' signatures indicating their involvement in planning their care. The standard of documentation was good, records were contemporaneous and there was evidence of ongoing mental health assessments completed.

Local policies and procedures were available to guide staff on the admission and discharge of patients. Nursing staff confirmed they were familiar with the Trust's Integrated Admission and Discharge Policy (May 2017) and they were aware of the need to complete assessments and care plans in a timely manner. The Crisis Response Team provides ward staff with a detailed handover prior to patients being admitted to hospital from their service.

There was evidence of MDT input, ongoing treatment plans and evidence of contact with the patients' key workers. It was noted patients had been referred for assessment of physical health needs such as seeing a dentist and referral to an ear nose and throat specialist.

Staff and patients confirmed that patients had access to a wide range of professionals to support them during their stay. We observed a high level of therapeutic engagement with patients amongst nursing and occupational therapists (OT) staff.

Delays were observed in completion of patient discharge letters. The Trust's Integrated Admission and Discharge policy (May 2017) states General Practitioner (GP) discharge letters must be completed within seven days of the patients discharge. This may impact on the patients' GP having timely access to information. This issue was not related to over occupancy. An area for improvement has been made.

Overall, we determined that patient care and treatment was not being compromised as a result of over occupancy.

5.2.7 Staffing

Staffing was reviewed to determine if safe staffing levels are being maintained when wards are over occupied

We met a range of staff including, nursing; ancillary; medical; social work; and OT staff. Staff advised that staffing levels were safe, and whilst there were occasions when there were staffing deficits, this did not impact on care delivery.

A staffing model (ALAMAC) based on patient acuity was being used across all the acute mental health inpatient services. ALAMAC is a live tool that risk assesses staffing levels on a daily basis, which are reviewed by senior managers. A recent review of staffing levels has resulted in additional Deputy Ward Managers posts being secured, enhancing the leadership across the wards. Staff described this as a positive outcome of the review.

Staffing levels were reported to be satisfactory; however deficits can occur due to short term sickness but managers work effectively to rectify this through clear escalation strategies. There was recognition that the Covid-19 pandemic had also impacted on staffing due to shielding and the requirement for isolation. Staff highlighted that they felt well supported by their line managers and senior staff. Managers and senior staff were described as approachable and staff reported ease in reporting any concerns.

At times the Trust use agency staff to cover deficits in shifts, the Trust strive to keep agency staff usage to a minimum and on average four shifts per day to include night duty are covered by agency staff. The Trust also make use of bank staff to cover deficits in shifts. The pool of bank staff are largely staff who previously worked in the service, have retired and have subsequently joined the Trust's nurse bank. Utilising this cohort of staff enhances the safe delivery of care as these staff are experienced in working in mental health wards. There were good relationships evidenced between the nursing teams across all wards to support when short staffed.

Ward managers and deputy ward managers had an additional role of bed management on a daily basis. This role was rotated between sites and enabled a clear process of escalation to senior management and the Bed Flow Coordinator on a daily basis in relation to staffing levels. Staffing levels are critical to decision making to support admission of acutely unwell patients.

Staff rotas evidenced an increase in staffing when a patient required a higher level of observation for a period of time or when there was a new admission to the ward. There was evidence that staff sickness levels were low and very few nursing vacancies across all wards. It was established that staffing was appropriate to meet patient need.

A review of the staff training matrix reflected that staff were compliant with mandatory training. Staff stated they had up to date supervision and appraisals in place.

The psychology staffing compliment has been achieved for the wards. Staff informed us this has been a positive appointment with the provision of a clinical role for patients and additionally a support to nursing staff through reflective practice sessions. A recent appointment of an activity nurse on the T & F site has had a positive impact in enabling therapeutic activities for patients. This role was in addition to the current complement of staffing. Given the positive outcomes for patients that this post has brought we asked the Trust to consider establishing the role on the Grangewood site.

Meetings took place with the OT who told us the service compliment currently consists of three OT staff providing clinical support to all wards to include PICU beds. OT told us of their daily role and how care is delivered based on priority of assessed need which reflected a pragmatic approach to delivering care.

We determined that staffing supported the delivery of a safe an effective service. When patient admissions increased there was evidence that appropriately trained staff were available to cover any deficits. This included times when the wards were over occupied.

5.2.8 Staff views

We met with staff to seek their views regarding the impact of over occupancy on the delivery of patient care.

Staff reported that morale throughout wards was good and that they were well supported by managers who were both visible on wards and approachable to support staff practices. Staff advised of the good relationships amongst all staff disciplines and the strong multidisciplinary working throughout the service.

Staff reported that despite the added pressures of over occupancy, the standard of patient care remained high. Over the last year there were more patients, who required admission, and this impacted the need for escalation beds, although, this had eased over recent weeks. Staff reported this can impact on the time available to spend with patients but that staff prioritised care delivery based on assessed need.

Staff reported clear mechanisms for communication, feedback and learning through staff meetings, safety briefs, emails, minutes, clinical supervision and verbal communications. All staff described recent improvements within their area of work, including new risk protocols, incident reporting guidance, new decoration and furniture, and the employment of a new activity nurse in Elm and Lime wards.

Of note, all staff commented that they would be happy for a close family member to be cared within each ward.

Overall, staff reported that a high standard of patient care was maintained when wards were over occupied.

5.2.9 Patient views

We met with patients to determine if over occupancy was affecting the delivery of their care.

Patients told us they were treated with dignity and respect and felt that staff actively listened to them and attended their needs. Patients advised that staff involve them in all aspects of their care and they each had the opportunity to attend meetings about their care. Patients told us they felt safe in the ward and no one reported having experienced restrictive interventions. Patients told us of the various therapeutic activities that they are involved in which included walks, art and craft, board games and 1:1 time with named nurse.

It was observed that patients were well cared for and were supported by compassionate staff Overall over occupancy was not affecting the experience of patients.

5.2.9 Medicines management

Medicines management was reviewed to determine if patient medicines was effectively being managed at times of over occupancy.

Ward pharmacist support was provided across all four wards. Staff were complimentary of the pharmacist support to the wards and their contribution to the safe management of medicines. The pharmacist supported all wards in relation to medication history taking and medicines reconciliation for newly admitted patients as well as regular review of prescribed medicines.

Medicine kardexes were well maintained in each of the wards including reasons for omitted medicines. The patient's drug allergy status was recorded on all of the kardexes examined. Staff were familiar with the arrangements for ensuring timely supply of prescribed medicines including medicines required during out of hour's periods. Staff exhibited knowledge of escalating to the prescriber in instances where patients refused medicines.

The management of medicines prescribed on a "when required" (PRN) basis was reviewed across all four wards. In all four wards, prescribed PRN medicines had clearly stated minimum dosing intervals and maximum doses to be administered in 24 hours documented.

Whilst acknowledging that in some instances the indication for the PRN medicine was documented, this was not consistent and not always recorded. In instances where more than one PRN medicine was prescribed for distressed reactions, it was not always clear which medicine was first, second or third line. There was no documented time interval for administration between first and second line PRN medicines for distressed reactions. Review of patient care plans did not include detail on first and second line PRN medications. In instances were PRN medicines were administered, the reason for and outcome of the administration was documented in the patients daily notes on some but not all occasions. An area for improvement has been made in relation to the use of PRN medicines in Elm and Lime wards.

Clozapine was supplied to the wards on a named patient basis and staff were aware of the requirement for regular blood monitoring. Arrangements were in place for regular review and monitoring of Clozapine treatment in all four wards. Signed patient clozapine care plans were observed demonstrating patient involvement in medicines management.

There was evidence of regular review of those patients on Lithium therapy including blood monitoring and documenting rationale for dose changes.

Medicines were stored in locked cupboards and medicine areas were clean, tidy and organised. Staff advised that the medicine trolleys only contained medicines for current patients. This is good practice. Resuscitation trolleys were stored safely and daily trolley audit records were observed.

In relation to the cold storage of medicines, we found that staffs were not recording the daily current, minimum and maximum medicine refrigerator temperatures. To ensure that medicines are stored in accordance with the manufacturers' specifications, staff must ensure that refrigerators are maintained between $2^{o}C$ and $8^{o}C$. Discussions with the ward manager assured us the Trust would address the recording of fridge temperatures.

The management of controlled drugs was reviewed. Controlled drugs which required safe custody were stored appropriately and stock balances were reconciled at shift changes. Controlled drug safe keys were carried by the appropriate person and records indicated that two staff were involved in the receipt, administration and disposal of controlled drugs.

Arrangements were in place to manage medicines when the patient was discharged from the ward and for patients on a period of temporary leave, to ensure a continuous supply of their medicines.

Appropriate arrangements were in place to ensure correct and safe disposal of medicines. Records of disposal were maintained and waste disposal bins observed were stored in a secure area in the treatment rooms.

The governance arrangements for medicines management were discussed. Controlled drugs were audited on a quarterly basis and this was evidenced in the controlled drug register. There was evidence of a monthly missed dose audit documenting the number and reasons for missed doses including any critical medicines involved. Findings from the audit are shared with ward staff to identify recurring trends and minimise missed doses of medicines. It was evident there were robust process in place for governance for medicines management in the Trust. Overall patient medicines were being effectively managed during times of over occupancy.

5.2.10 Governance and Leadership

Governance and leadership was reviewed to ensure effective mechanisms of communication, senior decision making and escalation arrangements when admitting patients when wards are over occupied.

Good leadership and governance was identified across both sites to promote the delivery of safe and effective care. Each ward had a cohesive team and good working relationships between the ward manager and their staff. Senior staff and managers were visible and approachable on wards to support staff practices. There was good multidisciplinary working across all disciplines and good collaborative cross site working to ensure consistency of practices.

The Mental Health and Disability Directorate Governance structures have been reviewed and funding approval had been agreed for a number of lead posts to augment the governance team. There was evidence of a number of committees, forums and meetings to support governance across the Directorate.

Leadership across the Directorate has been strengthened by improvements to the Operational management and lines of accountability. There is a single Assistant Director/Divisional Clinical Director now responsible for In-patient and Crisis Services, with an aligned single head of Service and Service Managers on each site.

The decision to admit patients to wards when they were over occupied is considered and only agreed as a last resort when risks to patients are high and no other treatment pathway is available in the community. Arrangements are in place for reporting and escalating over occupancy within the Trust and at regional level. Information goes through Bronze command in the Trust and up to Silver Command and any significant concerns are also escalated to the Public Health Agency, Health and Social Care Board or Department of Health. Bronze and Silver command structure is a command hierarchy for reporting of major incidents to ensure appropriate escalation during the Covid-19 pandemic.

Although Bronze and Silver meetings had been stood down throughout the region, the Trust Executive Team had committed to the continuation of these structures to enhance their escalation processes. Decisions around the issuing of regional Early Alerts are taken within the Silver Command forum.

A risk based approach is taken around decision making and escalation arrangements when admitting patients to beds when wards are over occupied. It involves discussions at senior nurse level and further escalation should risks necessitate. A Friday huddle meeting attended by senior managers on call, the Crisis Service Manager and Consultants on call, is used to facilitate decision making of bed management at weekends.

Effective mechanisms of communication, senior decision making and escalation arrangements were in place when admitting patients to beds when wards are over occupied was in place.

6.0 Conclusion

On reviewing our inspection findings it was evident that the effects of over occupancy were not compromising the delivery of safe and effective care.

While on occasions the Trust was operating over and above their commissioned beds, the impact on patients and staff was minimal. It was evident that the Trust had clear lines of communication and escalation and appropriate actions have been taken to ensure safe staffing levels based on patient acuity. The effective leadership at ward and senior management level has enabled the Trust to deliver a safe and compassionate service whilst embedding a least restrictive approach to supporting people with mental illness**.**

Based on our assessment of the 11 key themes, we are satisfied that this service is providing safe and effective care in a caring and compassionate manner while managing the risks of over occupancy. We have identified five areas for improvement that will further support the Trust to deliver improved outcomes for patients and staff.

7.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified were 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).

	Standards
Total number of Areas for Improvement	4*

**The total number of four areas for improvement have been identified which includes one that has been stated for a second time.

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

Quality Improvement Plan

Action required to ensure compliance with The Mental Health (Northern Ireland) Order 1986 and The Quality Standards for Health and Social Care DHSSPSNI (March 2006).

Area for improvement 1 **Ref:** Standard 5.1 Criteria: 5.3 (5.3.1) (f) **Stated:** First time **To be completed by:** 12 October 2021	The Western Health and Social Care Trust should take steps to improve their bed management processes by: • developing a local escalation policy to manage bed pressures which supports Trust staff to effectively manage fluctuations in capacity and demand with a consistent approach; • developing a local policy for 'on leave from inpatient care' which includes the actions to be taken if a patient who is 'on leave from inpatient care' and whose bed has been used to accommodate another patient, unexpectedly returns; • maximising the use of their IT systems to collate data such as bed occupancy to include category of admissions and length of stay. Review and analysis of this information is integral for optimising patient flow • working in collaboration with other bed management colleagues in other trusts to ensure a collaborative and effective approach to managing beds across the region. Ref: **5.2.1**
	Response by responsible person detailing the actions taken: 1.1 WHSCT Bed Managment Protocol covers both local escalation plans and on leave from inpatient care. 1.2 Integrated Admission and Discharge policy remains in draft pending final sign off. 1.3 On a daily basis a bed management plan will be communicated through the appopriate IT Systems. WHSCT will utilize the IT System and complete the daily Regional Bed Capacity report that is used to inform the Region of the current bed capacity 1.4 From appointment of the bed flow co-ordinator within WHSCT they have developed positive working relations with their collegues in the other trust areas. On a daily basis they communicate with each other at an agreed time to look at the current bed state within the Region. This huddle ensures collaboration between all Trusts to assist with the effective management of Acute In-patient Psychiatric beds not only within the WHSCT area but throughout the Region. The WHSCT Bed flow Co-ordinator facilitaes the local bed managers linking daily to review planned discharges, delayed

	discharges and general flow within the system. From this meeting a local plan is agreed around vacant beds, leave beds and the escalation plan will be for that night. This information is shared with the on-call senior manager for AMH to ensure the smooth admission/ discharge of patients out of hours. This also includes a weekend huddle for the on-call managers and consultants on call each Friday evening.

Area for improvement 2 **Ref:** Standard 5.1 Criteria: 5.3 (5.3.1) (f) **Stated:** Second time **To be completed by:** 12 October 2021	The Western Health and Social Care Trust shall address the following matters in relation to infection prevention and control: • improve the standard cleaning of sanitary wear; • commence a programme of decluttering, and reorganisation of storage areas; • take action to improve the cleaning and organisation of domestic cleaning equipment and stores. • ensure mattresses are cleaned and maintained and where necessary replaced. Mattress audits should be conducted and identified issues actioned. • Robust monitoring of these areas should be in place to provide continued assurance. **Ref: 5.2.2**
	Response by responsible person detailing the actions taken: 2.1 With the increased flow of patients within the Acute Adult Mental Health wards the general clening of the ward has been increased with particular attention payed to sanitary wear.The evironmental cleanilness audits will quality assure this work. 2.2 Decluttering of the Wards within Grangewood and additional shelving installed has been completed. Within T&F Hospital this process has commenced. 2.3 This work has been completed and will be quality assured by the ongoing enviromental cleaniness aduits . 2.4 All mattress within Elm and Lime ward and 2 mattresses in Grangewood have been replaced. The mattress audit has been increased to montly from June 2021 and reviewed and shared throught the monthly Team Health checks. They also are collated onto the appropriate dashboards. 2.5 The wards routine weekend cleaning template has been revised to include decluttering and general cleaning of the wards storage areas.

Area for improvement 3 **Ref:** Standard 8.1 Criteria: 8.3 (i) **Stated:** First time **To be completed by:** 12 October 2021	The Western Health and Social Care Trust shall review the process around discharge letters in line with Trust policy to ensure discharge letters are completed within 7 days of the patients discharge. **Ref: 5.2.6**
	Response by responsible person detailing the actions taken: WHSCT and in particular within the Tyrone and Fermanagh Hospital site has experieneced a significant increase in admissions; in excess of the 26 beds commisioned for the site. This has added additional pressure to the current staff in achieveing compliance with all discharge letters completed within 7 days of discharge. A QI iniative has looked at 2 issues; 3.1- Outstanding discharge letters 3.2- New ways of working to ensure that once the backlog is completed that the WHSCT does not find itself in this situation again. 3.1The HOS, AD and Clinical leads are considering all options such as re-deployement and other additionality to the existing medical team to support them to get the backlog completed as timely as possible. 3.2 The MDT have reviewed their processes and are currently trialling a new system in that a patients discharge letter is commenced on admission and at each review the letter is updated. This system then allows a draft discharge to be completed throughout the patients journey in hospital and is reviewed and approved on discharge. This new way of working reduces the risk of WHSCT being back in this position. This QI project commenced in Sept 2021 and is reviewed on a monthly basis. It will form part of the Team Health Checks.

Area for improvement 4 **Ref:** Standard 5.1 Criteria: 5.3 (5.3.1) (f) **Stated:** First time **To be completed by:** 12 October 2021	The Western Health and Social Care Trust should review the management of "when required/PRN" medicines prescribed for distressed reactions in Elm and Lime wards to ensure that; • kardexes clearly specify the indication for each medicine and if more than one medicine is prescribed, this clearly states which is first line and second line (where prescribed) • the time intervals between first and second line medicines (where prescribed) is clearly stated in the patient's kardex and/or care plan • the reason for and outcome of each administration is recorded on each occasion **Ref: 5.2.9**
	Response by responsible person detailing the actions taken: The management of PRN medicaiton is under review in Elm and Lime wards. Kardexes will include clear indications and time intervals. Medication administered will be clearly documented.

Please ensure this document is completed in full and returned via Web Portal

The Regulation and Quality Improvement Authority

7th Floor, Victoria House
15-27 Gloucester Street
Belfast
BT1 4LS

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews

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