Announced Enforcement Inspection Report
29 June – 7 August 2020

Western Health & 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

Lynn Long	Acting Deputy Director, Improvement Directorate Regulation and Quality Improvement Authority
Emer Hopkins	Interim Director, Improvement Directorate Regulation and Quality Improvement Authority
Thomas Hughes	Senior Inspector, Hospital Programme Team 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
Marie Therese Ross	Inspector, Hospital Programme Team Regulation and Quality Improvement Authority
Lorraine O'Donnell	Inspector, Hospital Programme Team Regulation and Quality Improvement Authority
Jill Campbell	Inspector, Hospital Programme Team Regulation and Quality Improvement Authority
Gary McMaster	Inspection Coordinator Regulation and Quality Improvement Authority
John Hughes	Inspection Coordinator Regulation and Quality Improvement Authority

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

1.0 What we look for

2.0 Profile of the hospital

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 (Northern Sector). 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 in each ward can also be created meaning a total of six PICU beds are possible if required.
Elm and Lime wards are situated in Tyrone and Fermanagh (T&F) Hospital, Omagh (Southern Sector). 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 have access to a multi-disciplinary team (MDT) that includes; consultant psychiatrists; doctors; nurses; occupational therapists and social workers. A pharmacist/pharmacy technician visits the wards every week. Patients have access to a physiotherapist, and clinical psychology therapy service by referral. A patient and carer advocacy service is also available for patients receiving care on the wards.

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 (WHSCT)	**Ward Managers:** Carrick: Kellie McGilloway Evish: Ciara Stewart Elm: Mary Maguire Lime: John Doherty
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: Ms Karen O' Brien, Director of Adult Mental Health and Disability Services.	

4.0 Inspection summary

We undertook an announced inspection of the Western Health and Social Care Trust's (WHSCT) Acute Mental Health Inpatient Wards from 29 June - 7 August 2020.

The purpose of this inspection was to assess compliance with the action points contained within the extended Improvement Notice - IN000002E which related to the recognition and management of adverse incidents and near misses across the Directorate of Adult Mental Health and Disability Services.

Due to the current impact on all services as a result of Covid-19 we conducted a risk assessment and determined that a blended approach to this inspection would reduce the risk of transmission of the virus and provide us with the level of assurance required to determine if the actions contained in the Improvement Notice had been met. To facilitate this approach we requested electronic submission of a range of information from the Trust.

Following review of the information submitted, three inspectors undertook a time-limited and focused inspection to the T&F hospital site on 7 July from 11:00 to 17:00 hours.

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 DHSSPSNI (March 2006).

On 22 July 2019 RQIA issued an Improvement Notice to the Trust in respect of a failure to comply with minimum standards. 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 Improvement Notice must be achieved was 22 October 2019.

We conducted an inspection from 13 to 14 of November 2019 to assess compliance with Improvement Notice - IN000002. We found evidence of some improvement and progress made against all of the required actions within the Improvement Notice but we did not find sufficient evidence to validate full compliance with the Improvement Notice. Following that inspection, we held two meetings with the Chief Executive of the Trust and members of the Trust's senior management team (SMT) on 20 December 2019 and 22 January 2020. At these meetings 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 determined more time would be required to achieve full compliance with the Improvement Notice. It was decided that the date of compliance with the Improvement Notice IN000002 should be extended. Compliance with the extended Improvement Notice must therefore be achieved by 22 June 2020. The extended Improvement Notice – IN000002E was issued on 5 February 2020.

This inspection sought to assess the level of compliance achieved in relation to the action points contained within Improvement Notice IN000002E.

4.1 Inspection outcome

Total number of areas for improvement	15*

**Fifteen areas for improvement identified during the inspection undertaken on the 13 and 14 November 2019 were not reviewed as part of this compliance inspection and will be carried forward to the next inspection. No new areas for improvement were identified during this inspection.

As a result of the findings of this inspection we determined the Trust had achieved compliance with the extended Improvement Notice - IN000002E.
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/

Enforcement notices for registered establishments and agencies 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

Prior to the inspection, we reviewed a range of information relevant to the establishment including the following records:

- written and verbal communication received since the previous inspection;
- notifiable events received since the previous inspection;
- the previous inspection report; and
- the extended Improvement Notice - IN000002E.

In order to complete our blended inspection we requested the following records from the Trust on the 24 June 2020 which were received on 29 June 2020:

- the historic Datix report;
- minutes of staff meetings from across the directorate;
- minutes of senior management meetings;
- minutes of multidisciplinary team (MDT) meetings;
- ward safety briefs / handover sheets for a four week period for all four wards;
- audits of the review of ward safety briefs and MDT meetings;
- copies of incidents reported via Datix for a four week period for all four wards;
- revised governance structures;and
- training records for staff inputting and managing incidents recorded on the Datix system.

We requested further information from the Trust on 15 July 2020:

- the completed historical Datix incident review report;
- evidence highlighting improvement in the grading of incidents in the northern sector;
- evidence of peer review/cross-referencing of incidents across both sectors of the service and an increase in sample size of audits;
- evidence of the effective identification and use of trend incident data; and
- a sample of one recent action sheet per ward to evidence actions arising from the Datix handlers review of open incidents.

We agreed a timeframe of three weeks for the additional information to be provided. The information was received on time and reviewed on 7 August 2020.
We examined the following area:

- Recognition and management of incidents and near misses.

The findings of the inspection were provided to Dr Anne Kilgallen, Chief Executive, WHSCT at the conclusion of the inspection by letter.

6.0 The inspection

6.1 Review of areas for improvement from the last care inspection dated 13 and 14 November 2019

As previously outlined in section 4.0 this inspection focused on assessing compliance with the action points within IN000002E. Fifteen areas for improvement identified during the last inspection on 13 and 14 November 2019 were not reviewed as part of this inspection and will be carried forward to the next inspection. The QIP in section 7.2 reflects the areas for improvement which will be carried forward to the next inspection.

6.2 Inspection findings

Improvement Notice Ref: IN000002E

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.

Failure to Comply

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.

Improvement necessary to achieve compliance:

The Chief Executive, Executive Team and Director of Adult Mental Health and 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.
2. 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.
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.

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.
5. 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.

Action Point 1

The Chief Executive, Executive Team and Director of Adult Mental Health and 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.

We were informed that the Trust had completed the first phase of the review of Datix incidents. The Trust outlined that this review incorporated three phases. Phase one was to review the historical open Datix incidents. Phase two was to review historical closed Datix incidents to ensure the incidents had been correctly graded and that the appropriate actions had been taken prior to closing. The findings from phase one and two would inform phase three of the review. Phase three would review similar, more recent incidents to reflect the improvement in the grading of incidents which had come from the learning identified in the previous phases. The Trust informed us that the findings from the first two phases were used to create a baseline audit of incident management for phase three.

The SMT shared their findings of phase one and we were satisfied that the Trust had identified sufficient learning from their review and had put an action plan in place to apply the learning going forward. This necessitated additional training for staff to ensure more detail and better quality information was provided in the incident reports and that details regarding the outcome of incidents was also recorded. The SMT also understood the need to involve other disciplines in the training and to use Datix to its full potential in generating reports to identify themes and trends such as the cumulative effect of multiple incidents on staff and identify multiple incidents involving the same patient.

Phase two of the review had been delayed due to the impact of Covid-19 but on completion of phase two, SMT provided evidence that a random selection of closed Datix incidents had been reviewed. The SMT informed us that the incidents reviewed had been correctly graded and appropriate actions had been taken for each incident.

The third phase of the review had also been delayed due to Covid-19 and we were assured by SMT that it would be completed by the end of July 2020. They shared the findings from phase three within the agreed timescale and the data they provided demonstrated that the learning from the historical review had been meaningful.

Our initial analysis of the information provided by the Trust suggested that the newly developed processes emanating from the findings of the historical review had been more fully embedded in one sector compared to the other sector. We believed that one sector had significantly improved in their grading of incidents in comparison to the other sector and that the practice of peer review was inconsistent across sectors which may have contributed to this variation. We were respectfully challenged by the SMT about this conclusion and they informed us that the information we had requested prior to the inspection related to dates when the impact of Covid-19 on the service was high. The Trust's SMT agreed to submit additional information (as outlined in Section 5.0) which they believed would provide us with assurance that improvements in the grading of incidents were embedded well in both sectors. The additional information was submitted within the agreed timeframe and from the audit of current Datix incidents, we evidenced significant improvements in the grading and escalation of incidents within both sectors.

We were satisfied that the Trust had completed a robust review, which addressed the key areas of concern which we identified during our previous inspections in June and November 2019.

Outcome of Action Point 1

We determined this action point had been met.

Action Point 2

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

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.

The Trust had identified from the historical review of Datix incidents that certain risks in relation to fire and ligature warranted a high-risk grade and timely escalation to SMT. From our review of the Datix incident audits there was evidence that high risk incidents were addressed in a timely manner and appropriate actions were taken and any incorrectly graded Datix incidents were quickly rectified.

We saw evidence of prompt cards/aide memorie which guided staff when inputting information on Datix. In particular staff were guided to grade all fire and ligature incidents as high risk. There was a risk matrix available to staff when completing Datix which also served as a guide to staff. During our discussions with staff we were assured that they knew that fire and ligature incidents were to be graded as high risk and they told us the prompt cards and matrix were helpful.

From our review of the daily ward safety briefs and Datix incidents we found evidence that incidents which were graded as high risk were automatically flagged to SMT in a timely manner. This provided us with assurance of improved SMT oversight and management of incidents particularly around fire and ligature risk.

We reviewed the minutes of staff team meetings and found evidence that learning from incident reviews was shared. Staff were required to sign the minutes to confirm they were aware of what was discussed daily.

We reviewed action sheets which arose from incidents and saw evidence that appropriate actions had been delegated to specific staff who were required to sign to evidence the completion of their delegated action.

We found evidence that four incidents were discussed at a Rapid Review Group and the discussions highlighted the need to progress one incident to be investigated under the Health and Social Care Board's Procedure for the Reporting and Follow Up of Serious Adverse Incidents (2016) as it was recognised that the learning arising from the incident should be shared regionally.

Outcome of Action Point 2

We determined this action point had been met.

Action Point 3

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

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 a sample of Datix incidents and triangulated information from the relevant patient care records, risk assessments and safety briefs. We were assured that there was an improvement in the quality of information provided on the Datix report and in the grading of incidents. We also saw evidence that timely actions for each incident had been taken. On previous inspections in June and November 2019, we had been concerned that incidents were being graded on the outcome rather than on the inherent risk of the incident. There was evidence that incidents were now being graded based on the inherent risk.

We reviewed three months Datix audits from all wards and could see that outcomes from the audits were discussed with the ward managers in clinical supervision. Audits highlighted if an investigation into an incident was not satisfactory or where learning from an incident was not detailed enough. If an incident was wrongly graded this was also identified. It was good to note that the Trust had doubled the audit sample size as we had recommended and we were informed that they planned to resume peer review of audits now that the impact of Covid-19 had lessened.

Band six and Band seven nursing staff had completed enhanced Datix training as they were Datix handlers and were responsible for approving Datix entries. During our interviews with staff, it was evident that staff were knowledgeable that the role of the Datix handler was to review each Datix incident entry, to ensure the incident was graded correctly and identify any immediate learning.

There was improved compliance with Datix inputter training and there was recognition by the SMT that this training needed to be provided on an ongoing basis for new staff ; a rolling Datix training programme was planned. We determined that the Datix training had produced significant improvements in the grading of incidents. There was evidence that Datix training was being provided across the disciplines and the staff we spoke with (nursing, medical and allied healthcare professionals) demonstrated good knowledge and awareness of completing Datix incident reports and the need for timely escalation of certain incidents.

Outcome of Action Point 3

We determined this action point had been met.

Action Point 4

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

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 minutes of two Adult Mental Health Senior Management Governance Meetings. This meeting occurs monthly to discuss incidents and other pressing issues eg: SAIs, complaints, compliments and litigations, quality and risk management, governance including risk register and annual generic risk assessments. It was evident that incident management is a standing agenda item.

We reviewed the minutes of four Directorate Governance Meetings. This meeting occurs fortnightly and includes detailed discussion about risk and incident management, SAI's and quality improvement work streams planned or underway to ensure continuous improvement of incident management.

We were informed that the Clinical Quality & Safety Quarterly Report along with auditing of Datix incidents were the Trust's way of testing its incidents and risk management system.

We reviewed the minutes of Governance Meetings, MDT Meetings, Rapid Review Meetings and Team Health Checks, and established that the Trust had a process in place which provided regular updates on the spectrum of incidents.

We were provided with data which demonstrated the work which had commenced in relation to trend analysis of incidents. This data showed there were triggers in the system which alerted the SMT when numbers of certain incidents rise beyond a certain level. We saw evidence that when this occurs, an explanation is provided.

Outcome of Action Point 4

We determined this action point had been met.

Action Point 5

The Chief Executive, Executive Team and Director of Adult Mental Health and 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.

We were provided with a flow chart demonstrating the governance and improvement structure within the Directorate of Adult Mental Health and Disability. The SMT provided further details of the structure during our meeting with them on 3 July 2020. Staff (nursing, medical, AHP's) confirmed during discussion that this chart is displayed within the wards and it was clear that staff were knowledgeable about the process of escalating risks. We determined that the Trust had strengthened its structures to review, approve and escalate all incidents, adverse incidents and near misses captured in the Trust's Datix system. The SMT confirmed there was support from Trust Board and that Trust Board is notified of certain incidents. A number of staff described to us the positive impact the Improvement Notice had on their practice and that on reflection how beneficial the journey had been.

Outcome of Action Point 5

We determined this action point had been met.

6.3 Conclusion

We found sufficient evidence was available to validate compliance with all action points contained within IN000002E.

7.0 Quality improvement plan

There were no new areas for improvement identified during this inspection. The attached QIP contains the areas for improvement carried forward from the last inspection on 13 and 14 November 2019. The areas for improvement will be reviewed at a subsequent inspection.

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

7.1 Areas for improvement

No new areas for improvement were identified during this inspection. The attached QIP includes areas for improvement identified during the last inspection on 13 and 14 November 2019.

7.2 Actions to be taken by the service

The Trust is not required to return a completed QIP for assessment by the inspector as part of this inspection process. The QIP reflects the carried forward areas for improvement from the inspection on 13 and 14 November 2019

<table>
<tr><th colspan="2">Quality Improvement Plan</th></tr>
<tr><td colspan="2">Action is required to ensure compliance with The Quality Standards for Health and Social Care DoH (March 2006)</td></tr>
<tr><td colspan="2">Risk Assessments</td></tr>
<tr><td rowspan="2">Area for Improvement 1

Ref: Standard 5.3.1 (a)

Stated: Second time

To be completed by:
7 November 2019</td><td>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.
•</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 for review at the next inspection.</td></tr>
<tr><td colspan="2">Nurse Training on Psychological Formulation</td></tr>
<tr><td rowspan="2">Area for Improvement 2

Ref: Standard 4.3 (m)

Stated: First time

To be completed by:
7 November 2019</td><td>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.</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 for review at the next inspection.</td></tr>
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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.
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward for review at the next inspection.
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.
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward for review at the next inspection.
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.
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward for review at the next inspection.

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.
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward for review at the next inspection.
Resuscitation and management of medical emergencies	
Area for improvement 7 **Ref**: Standard 5.3.1	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.
Stated: First time **To be completed by:** 7 July 2019	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward for review at the next inspection**.**

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.
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward for review at the next inspection.

Environment	
Area for improvement 9 **Ref**: Standards 4.3 and 5.3. **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.
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward for review at the next inspection.

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.
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward for review at the next inspection.
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.
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward for review at the next inspection.

<table>
<tr><th colspan="2">Therapeutic Activity</th></tr>
<tr><td rowspan="2">Area for improvement 12

Ref: Standards 5.3.3 6.3.1 and 6.3.2

Stated: First time

To be completed by:
7 November 2019</td><td>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 back to items discussed at the previous meeting and note any follow-up taken to address issues discussed.</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 for review at the next inspection.</td></tr>
<tr><th colspan="2">Organisational Governance</th></tr>
<tr><td rowspan="2">Area for improvement 13

Ref: Standard 4.3

Stated: Second time

To be completed by:
14 July 2020</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></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 for review at the next inspection.</td></tr>
</table>

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.
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward for review at the next inspection.
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.
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward for review at the next inspection.

The Regulation and Quality Improvement Authority

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