Lissan 1

Psychiatric Intensive Care Unit

Address: Holywell Hospital, 60 Steeple Road, Antrim BT41 2RJ

Dates of Inspection Visit: 31 May– 2 June 2016

Names of Inspectors: Alan Guthrie, Cairn Magill and Dr Brian Fleming

Summary of our Assessment

Is Care Safe?	Requires Improvement
Is Care Effective?	Requires Improvement
Is Care Compassionate?	Good
Is the Service Well Led?	Good

Please note: This assessment is based on the findings of this inspection and should be read together with the full report.

This report describes our judgement of the quality of care at Lissan 1 ward. It is based on a combination of what we found when we inspected and from a review of all of the information available to The Regulation and Quality Improvement Authority (RQIA). This included information given to us from patients, the public and other organisations.

This inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in this service. The findings reported on are those that came to the attention of RQIA during the course of this inspection while assessing the four stakeholder outcomes under this year's theme of Patient Centered Care. The findings contained in this report do not exempt the Trust from their responsibility the Mental Health (Northern Ireland) Order 1986 and the Department of Health (DoH) standards. It is expected that the areas for improvement outlined in this report will provide the Trust with the necessary information to assistant them to fulfil their responsibilities and enhance practice within the service.

Contents

1.0 Details of Ward

Lissan 1 is a psychiatric intensive care unit (PICU) located on the Holywell Hospital site, providing care and treatment to nine patients. The main entrance doors of the ward are locked in accordance to the assessed needs of the patient group. The ward provides care and treatment for male patients. On the day of the inspection the ward was at full capacity. Each of the nine patients had been detained in accordance with the Mental Health (Northern Ireland) Order 1986. Patients were supported by a multi-disciplinary team (MDT) that included a consultant psychiatrist, nursing staff, a social worker, occupational therapist, support staff and advocacy services.

2.0 Summary of this Inspection

This inspection focused on the theme of Person Centred Care.
This means that patients are treated as individuals, and the care and treatment provided to them is based around their specific needs and choices.

RQIA found that Lissan 1 ward provided compassionate care. Patients were complimentary regarding the care and treatment they had received. Patients were also positive regarding their relationships with staff. The care and treatment provided at ward level was well led by a MDT evidenced as being effective, well-coordinated and inclusive. All of the staff who spoke with inspectors stated that they enjoyed working on the ward and they felt supported and respected.

The overall leadership and management arrangements for the ward were assessed as good with five areas for improvement identified. Inspectors identified three areas for improvement in relation to aspects of providing safe care. Two areas of improvement are required to ensure care is delivered more effectively.

Two priority one recommendations have been made. These concern the need to commence work on the removal and management of ligature points (Safe) and the transfer and discharge of patients (Effective). Both of these matters have been brought to the immediate attention of the Trust. RQIA has received assurances from the Trust that both these concerns are being urgently addressed. Following the inspection RQIA will continue to monitor progress and the Lissan 1 ward.

Follow up on Previous Inspection Recommendations

Two recommendations were made following the most recent inspection on 21 May 2015. Both recommendations had been implemented in full.

1. The Trust had recently appointed a clinical psychologist. The psychologist's role will be to provide interventions to patients admitted to

the Trust's acute care mental health settings. Inspectors were informed that patients admitted to Lissan 1 could access the psychologist through referral.

2. Inspectors reviewed all toilet and shower areas located within the ward. Each area was available for patient use and noted to in an appropriate state of repair and cleanliness.

3.0 How we Carried Out this Inspection

RQIA's programmes of inspection, review and monitoring of mental health legislation focus on four specific and important key stakeholder outcomes:

Is care safe?
Is care effective?
Is care compassionate?
Is the service well led?

The inspection assessment is expressed using four levels of achievement in meeting the stakeholder outcomes:

Excellent
Good
Requires Improvement
Unsatifactory

What the inspector(s) did:

- Reviewed a range of information relevant to the facility sent to RQIA before the inspection. This included policies and procedures, staffing levels, ward aims and objectives and governance protocols.
- Talked to patients, carers and staff.
- Observed staff working practices and interactions with patients on the days of the inspection.
- Reviewed other documentation on the days of the inspection. This included care records, incident reports, multi-disciplinary procedures and staff training records.
- Reviewed progress since the last inspection.

At the end of the inspection the inspector(s):

- Commended areas of good practice.
- Shared the inspection findings with staff.
- Highlighted areas for improvement.

4.0 What People Said about this Service

Patients Stated:

During the inspection inspectors met with five patients. Patients informed inspectors that their relationships with staff were positive and they found staff to be approachable, supportive and easy to talk to. Patients reported feeling safe and secure within the ward and that staff treated them in a dignified and respectful manner. One patient reflected that they had experienced a good admission and introduction to the ward as staff had been helpful and had made them feel at ease. Four patients reported that they could not remember their admission as they had been unwell.

Patients who spoke with inspectors reported that they were unhappy at having to remain in hospital. Two patients stated they felt involved in some decisions about their care and treatment. One patient reported they were not involved and two patients stated they had been fully involved. There was evidence in the patient care records that patients attended their multi-disciplinary team review meeting on a weekly basis and that care and treatment decisions were discussed with each patient. The patient's view was continually sought and considered.

Patients stated that staff listened to them and took their views into account. Patients also informed inspectors that staff always sought permission before providing support. It was positive to note that patients considered that staff responded quickly to them when they needed help.

Patients Said:

"Good guys...well controlled (the ward)",

"Very respectful staff team",

"There is good privacy on the ward",

"Good atmosphere",

"Activities are good",

"Plenty of space although weekends can be boring",

"Food's good",

"Staff are friendly and helpful",

"Thing about this ward is that I sleep great",

“I’d like more freedom”,

“I really don’t want to be in hospital”,

“Don’t like the doors being locked”.

Relatives Stated:

During the inspection patient relatives/representatives were invited to meet with inspectors. One relative met with inspectors. The relative reflected that their experience of the ward had been positive despite their concerns about their family member. The relative stated that they felt their family member was now “One hundred times better”. The relative also said:

“I wasn’t dismissed by staff they took time to explain things to me”,

“I am kept up to date”,

“Staff treat me with respect”,

“My family member receives a lot of care and support”.

Inspectors left a number of questionnaires with the ward manager to distribute to relatives/representatives as required. No questionnaires were returned to RQIA.

Staff Stated:

Inspectors met with 11 members of the ward’s MDT. Staff told inspectors that they felt the MDT was supportive, inclusive, and effective and focussed on achieving the best outcomes for patients. All staff stated that they enjoyed working on the ward and that their contribution was valued, listened to and considered. Staff reported no concerns regarding their ability to access support, training, supervision and appraisal.

Inspectors spoke with three nursing staff. Staff were familiar with patients’ needs and demonstrated understanding of the ward ethos, purpose and policies and procedures. Nursing staff stated that the ward promoted a recovery culture and the treatment and care regimes had a positive impact on patients. Some concern was expressed that patients, at times, remained on the ward longer than was necessary. Inspectors reviewed the ward’s admission and discharge procedures and noted that the discharge and transfer of patients from the ward was completed in accordance to the Trust’s bed management procedures. Bed management decisions were made by the bed manager and not by the MDT. Delay in patients being transferred or discharged from the ward was an area of concern and is listed as an area requiring improvement in section six of this report.

Inspectors spoke with the senior social work practitioner. The social worker stated that patients' rights were at the centre of all decision making. The MDT was described as being effective, patient and family centred and consistent in its approach. The social worker was complimentary regarding the professionalism and focus of their MDT colleagues. Furthermore, they indicated the care and treatment interventions provided to patients were comprehensive, caring and based on the individually assessed needs of each patient.

In terms of challenges within the ward the social worker commented on the difficulty of ensuring that patients were discharged or transferred from the ward following the completion of their treatment in PICU. They explained that in their experience the delayed discharge of patients had been due to bed management pressures.

The social worker also considered that further enhancement of ward based therapeutic interventions to support patients presenting with anxiety, depression and or challenging behaviours (related to their illness), would be appropriate.

Medical staff informed inspectors that there were challenges regarding the discharge and transfer of patients from the ward. Staff explained that the MDT did not have direct links with the Trust's community mental health teams. Staff felt that alongside bed management pressures this was a key factor in causing the delay of patients being discharged from the ward. Medical staff also commented on the challenges of having to manage the discharge of some patients directly to the community.

5.0 Our Assessment of the Four Stakeholder Outcomes

5.1 Is Care Safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

Key Indicator S1 - There are systems in place to ensure unnecessary risks to the health, welfare or safety of patients are identified, managed and where possible eliminated.

Examples of Evidence:

v' Patient care records reviewed by inspectors were individualised and based on the assessed needs of the patient. Care plans were appropriately detailed and included plans specific to the each patient's legal status and the Trust's smoking policy and procedure.

v' Risk assessments were up to date and completed in accordance to regional and Trust policy and procedure. Plans were reviewed on a daily basis and comprehensively each week during each patient's MDT review meeting.

v' Patient care records reviewed by inspectors evidenced that risk assessments, care plans, MDT records and continuous care notes were patient centred. Patients' involvement in their plans was evidenced within records. Where patient signatures were not available a staff member had noted that the patient was receiving directed care. Decisions taken on behalf of patients lacking capacity were completed in line with best outcome principles.

Key Indicator S2 - The premises and grounds are safe, well maintained and suitable for their state of purpose.

Examples of Evidence

Ward Environment: Inspectors assessed the ward's physical environment using a ward observational tool and check list.

v' The reception area was well presented and included notice boards that displayed information relevant to patients and carers. There was information displayed in relation to advocacy services, the Trust's complaints procedure and the regional adult safeguarding procedures. Patients could also access a patient and carer information folder.

v' The ward had a large amount of information presented in easy to read format. This included information in relation to Human Rights, the Mental

Health (Northern Ireland) Order 1986 and the Mental Health Review Tribunal.

v' Inspectors' first impressions of the ward environment were that it was relaxed, welcoming and warm. Inspectors noted that staff were informal, friendly and respectful to patients. Patients presented as being at ease and comfortable in their surroundings.

v' Patients were observed as relaxed during lunch time. The dining room environment was clean and comfortable.

v' Patients shared an eight bedded dorm area and there was one single bedroom located off the main dorm area. Patients could independently screen off their bed area with the use of curtains. Bathroom and toilet facilities were accessible and located throughout the ward. Patients could lock bathroom doors and a call system was available in the bathrooms. There was a private room off the main ward area for patients to meet with their visitors and a separate private room on the main ward where patients could make a phone call. There was a large open lounge area and a large well maintained garden. Inspectors also evidenced that the ward had a recreational room, spacious bay areas and a comfortable dining area.

Area for Improvement:

× A large number of ligature points located on the ward require to be removed/managed. *Quality Standard (5.3.1f).*

Inspectors were concerned to note a number of ligature points located within the ward. These included taps and door fixtures. The Trust had completed an audit of the ligature points within the ward in July 2015. A large number of ligature points were recorded. A subsequent action plan had also been produced. The action plan detailed specific timetables within which ligature points would be removed, replaced or subject to a locally (ward staff) managed protocol. However, inspectors noted that the timelines for completion of ligature works had slipped and ligature points and associated risks remained.

The audit completed in July 2015 suggested that a number of ligature points could be managed by the ward staff. It was concerning to note that the suggested action plan, including the management of ligature points by ward staff, had not been agreed with the Ward Manager. Given the seriousness of these concerns, this issue was escalated to the Trust's Chief Executive and the Department of Health on the 10 June 2016. These concerns are discussed in the improvement plan in section six of this report.

Area for Improvement:

X The CCTV monitor used to support patients in the seclusion room required split screen capability to allow staff to monitor all areas. *Quality Standard (5.3.1f).*

Key Indicator S3 - **There are at all times, suitably qualified, competent and experienced persons working in the facility.**

Examples of Evidence

v' There were appropriate staffing levels on the days of the inspection. All staff on duty wore names badges. Information posted on the patient notice board, located in the main lounge area, included details of the ward doctor and other members of the MDT. Staffing skill mix on the days of the inspection was appropriate to the assessed needs of the patients. Staff were observed to be attentive and assisted patients promptly when required.

v' Staff informed inspectors that they enjoyed working on the ward and felt supported and valued. It was positive to note that the ward promoted a flat management structure and the opinions of all staff were welcomed, valued and considered. No member of staff reported any concerns to inspectors regarding their role and responsibilities, experience or training.

v' Staff who met with inspectors reported no difficulties regarding their ability to escalate concerns to senior management. Inspectors met with each member of the MDT. Staff stated that they felt the MDT was effective, responsive and supportive. It was also noted that all staff expressed satisfaction regarding their role and position within the MDT.

Key Indicator S4 – **Patients are detained appropriately with information provided about their rights and how to make a complaint.**

Examples of Evidence:

v' Patient care records reviewed by inspectors evidenced that all patients had been admitted to the ward under the Mental Health (Northern Ireland) Order 1986. Each file reviewed evidenced that patient care and treatment was being managed in accordance to the legislative requirements.

v' Patients who met with inspectors reported no concerns regarding their ability to make a complaint. Information regarding the ward's complaints procedure was available. Patients could also meet with the ward advocates as required.

Level of Achievement	Requires Improvement

5.2 Is Care Effective?

The right care, at the right time in the right place with the best outcome.

Key Indicator E1 - Comprehensive co-produced personal well-being plans/care plans are in place to meet the assessed needs of patients. Care and treatment is evaluated for effectiveness. Effective discharge planning arrangements are in place.

Examples of Evidence:

v' Treatment plans evidenced continued implementation of treatment in accordance to the assessed needs of each patient. It was positive to note that treatment plans and continuing care records evidenced that patients had responded well. It was also noted that the MDT promoted a culture of least restrictive practice and completed ongoing reviews to ensure the patients required continued care within a PICU environment. Patient assessment and care plans were comprehensive, based on the individualised needs of each patient and up to date.

v' Patient care records reviewed by inspectors evidenced that patients' care and treatment plans were reviewed daily by the MDT and comprehensively on a weekly basis during each patients review. Patients who met with inspectors stated that they were involved in their care and treatment and could attend their review meetings.

v' Inspectors evidenced that patients were, when appropriate to the patient's mental health, active participants in their care and treatment planning. Patients who met with inspectors confirmed that they were involved in their care and treatment plans. It was positive to note that the ethos of the ward was to provide least restrictive interventions and to support each patient's recovery and discharge from the ward.

v' Patient care records evidenced that discharge planning commenced upon each patient's admission. The wards MDT reviewed patient progress on a daily basis and as required. A MDT review meeting was held each week. Records demonstrated that each patient's discharge was considered on a continuous basis.

Areas for improvement:

✘ An audit and action plan is required in relation to the timely transfer/discharge of patients assessed as no longer requiring intensive psychiatric care. *Quality Standard 5.3.3(b).*

Care records reviewed by inspectors evidenced that patient care and treatment was provided in accordance to legislation, best practice standards and in the best interests of the patient. However, inspectors noted that the care pathways of two patients had not been delivered in line with their

assessed needs. The discharge of both patients from the ward had been delayed due to factors beyond the control of the ward's MDT.

This issue is discussed in the areas for improvement section (section six) of this report.

Key Indicator E2 - **Autonomy and Independence is promoted and the use of restrictive practice(s) is minimised**

Examples of Evidence:

V' Care records reviewed by inspectors evidenced appropriate care planning, comprehensive progress records and continuous MDT review. Patients and staff who met with inspectors reported that they felt the ward promoted an ethos of trying to ensure recovery and best outcome for all patients. Staff promoted a least restrictive practice ethos.

V' The ward was located in an old building and its design was not in keeping with best practice guidance. The Trust had taken steps to address this issue. A ligature audit had been completed in July 2015 and a subsequent action plan had been developed.

V' Care records reviewed by inspectors evidenced that the use of restrictive practices was based on each patient's individualised assessed need and presenting risk. Inspectors evidenced that restrictions were used proportionally and as a last resort.

Level of Achievement	Requires Improvement

5.3 Is Care Compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

Key Indicator C1 - **There is a culture/ethos that supports the values of dignity and respect and patients are responded to compassionately.**

Observations - Effective and therapeutic communication and behaviour is a vitally important component of dignified care. The Quality of Interaction Schedule (QUIS)[i] is a method of systematically observing and recording interactions whilst remaining a non- participant. It aims to help evaluate the type of communication and the quality of communication that takes place on the ward between patients, staff, and visitors.

Inspectors completed direct observations using the QUIS tool during the inspection and assessed whether the quality of the interaction and communication was positive, basic, neutral, or negative.

- **Positive social (PS)** - care and interaction over and beyond the basic care task demonstrating patient centred empathy, support, explanation and socialisation
- **Basic Care (BC)** – care task carried out adequately but without elements of psychological support. It is the conversation necessary to get the job done.
- **Neutral** – brief indifferent interactions.
- **Negative** – communication which is disregarding the patient's dignity and respect.

Examples of Evidence:

Observations of interactions between staff and patients/visitors were completed throughout the days of the inspection. Five interactions were recorded in this time period. The outcomes of these interactions were as follows:

Positive	Basic	Neutral	Negative
% 100	% 0	% 0	% 0

✓ Inspectors observed interactions between staff and patients during each day of the inspection. Inspectors noted that communication and contact between staff and patients was positive, supportive and respectful. Patients presented as relaxed and at ease in the company of staff. Staff were observed interacting with patients and providing care in a personal and sensitive manner in accordance to each patient's needs. Inspectors witnessed staff remaining proactive when engaging with patients.

v' Staff presented with an understanding of each patient's individual needs. This was demonstrated on several occasions when staff were observed supporting patients presenting as unwell. Inspectors evidenced that staff responded promptly and demonstrated a high level of skill when reassuring patients and de-escalating potentially challenging behaviour. It was also good to note that staff maintained a presence throughout the ward and remained alert and attentive to patients' needs.

v' There was information displayed on the ward in relation to daily activities and patients had their own individual activity timetable.

v' Patients were able to speak with staff or attend their multi-disciplinary team review. Information in relation to the ward round and the patient forum was shared with patients.

v' Meal times were protected and choice of meals was available. Staff were observed supporting patients in a timely and sensitive manner. Patients could access fresh water and a vending machine as required. Inspectors were informed that patients had requested that more choice be provided within the vending machine. This request was being brought forward by the Ward Manager with the vendor provider.

Key Indicator C2 - There are systems in place to ensure that the views and opinions of patients, and/or their representatives are sought and taken into account in all matters affecting them.

Examples of Evidence:

v' Inspectors evidenced that the MDT meeting was held each Wednesday and patients were involved in the meeting and in decisions relating to their care and treatment. In circumstances were a patient requested a representative of their choice to attend a meeting this was reviewed by the MDT and discussed with the patient. Inspectors were satisfied that should a patient request a representative to support them this would be supported/ reviewed by the MDT.

v' Patients who met with inspectors reported that they attended their MDT ward meeting and staff kept them informed of their care and treatment plans. Care records reviewed by inspectors evidenced that treatment options/regimes were discussed with patients on a regular basis. The ward provided a broad range of information for patient use including details regarding drug interactions and side effects, the Mental Health Review Tribunal, restrictive practices and information detailing patients' rights.

v' The patient information leaflet provided details regarding the use of restrictive practices. Audits carried out by ward staff evidenced that enhanced observations, physical interventions and seclusion were used to support patients. Inspectors reviewed records detailing situations where restrictive interventions had been used. The records reflected that the

interventions had been used appropriately and in accordance to the required standards.

✓ Patients could access the ward's advocates as required. The ward was supported by two advocates who visited on a regular basis. One of the advocates informed inspectors that ward staff supported and promoted the role of the advocate service. The advocate stated that they felt ward staff addressed patient concerns quickly and in a professional and personal manner.

Level of Achievement	Good

5.4 Is The Service Well Led?

Effective leadership, management and governance which create a culture focused on the needs and experiences of patients in order to deliver safe, effective and compassionate care.

Key Indicator WL1 - There are appropriate management and governance systems in place to meet the needs of patients.

Examples of Evidence:

v' There were effective systems in place to monitor patient progress and to report and analyse incidents, accidents and serious adverse incidents. The MDT implemented a number of care and treatment audits which were shared with the Trust's governance department and disseminated to all staff on the ward.

Key Indicator WL2 - There are appropriate management and governance systems in place that drive quality improvement.

Examples of Evidence:

v' The MDT had completed a number of PICU practice audits. These included use of rapid tranquilisation, patient movement through PICU and use of restrictive practices. The audits confirmed the appropriateness, frequency and context of use of these interventions.

Key Indicator WL3 - There is a clear organisational structure and all staff are aware of their roles, responsibility and accountability within the overall structure. There are appropriate supervision arrangements in place.

Examples of Evidence:

v' Staff who met with inspectors stated that they felt the culture within the ward promoted learning. All staff reported they enjoyed good working relationships with their colleagues.

v' Information regarding the organisational and management structure of Trust's mental health programme was posted on the notice board in the ward's main office and in the visitors' room. There were also contact details for community mental health teams and staff. This information was presented on a graph and also detailed staff roles and responsibilities.

v' All qualified nursing staff had completed their supervision and appraisal in accordance to professional and Trust standards. MDT members who met with inspectors reported no concerns regarding the support they received and their ability to access appraisal and supervision.

v' All staff who met with inspectors reported no concerns regarding their ability to access training.

Key Indicator WL4 - There are effective staffing arrangements in place to meet the needs of the patients.

Examples of Evidence:

v' The ward's rota evidenced that staff requirements were continually monitored and reviewed. Members of the staff team reflected no current concerns regarding staffing levels. Nursing staff reflected that the changing needs of the patient group made it difficult to plan shift patterns in relation to the number of staff required. Examples included circumstances were three extra staff were required in excess to the shift compliment (four staff) to support patients requiring enhanced observations. It was positive to note that bank shifts were largely completed by staff who held substantive posts on the ward or who had knowledge/experience of working in a PICU.

v' The wards MDT was appropriately staffed and all required professions were available. Staff understood their roles and responsibilities.

v' There was a clear management structure identifying the lines of responsibility and accountability.

v' Staff who met with inspectors reported no concerns regarding their ability to access support, training and supervision.

Areas for improvement:

X The extent of work required in relation to the progression of the ligature action plan should have been commenced earlier through better communication between senior levels to ward manager. *Quality Standard (5.3.1f).*

X The leadership and management to deal with the discharge/transfer of patients who no longer meet the grounds for detention requires review by Trust senior management *Quality Standard (5.3.3b).*

Level of Achievement	Good

6.0 Excellent Practice Noted

Inspectors evidenced that the ward staff team worked efficiently and effectively together and that the quality of care provided to patients was to a high standard. There was clear objective evidence that patients were treated in a compassionate and caring manner and that care planning was patient centred and inclusive.

Evidenced regarding the coordination of the MDT and feedback from staff demonstrated the ward benefitted from strong professional leadership. Inspectors' findings also evidenced that the ward promoted a patient centred culture.

7.0 Areas for Improvement

Areas for improvement are summarised below. The Trust, in conjunction with ward staff, should provide an improvement plan to RQIA detailing the actions to be taken to address the areas identified.

Key areas for improvement were discussed with the ward manager and other staff from the Trust involved in providing care/treatment to patients in this ward as part of the inspection process.

The timescale for action on the areas for improvement commenced from the day of the inspection. The QIP requires be completing by the Trust detailing the actions the Trust intend to take to make the required improvement and returning to RQIA within 28 days of receipt.

On return to RQIA the QIP will be assessed by the inspector.

Areas for Improvement		Timescale for Implementation in Full
Priority 1 Recommendations		
1	Ligature risks identified within the ward require a clear plan as to how they would be managed to help ensure patient safety.	1 July 2016
2	There was no clear action plan to deal with the efficient discharge/transfer of patients who no longer meet the grounds for admission to a PICU environment.	1 July 2016
Priority 2 Recommendations		
3	The work required to remove or replace ligature risks had not been commenced.	1 September 2016
Priority 3 Recommendations		
4	The CCTV monitor used to support patients in the seclusion room required split screen capability to allow staff to monitor all areas.	1 December 2016

5	An audit of the transfer/discharge arrangements for patients is required. This will help demonstrate improvement.	1 December 2016

Definitions for Priorty Recommendations

PRIORTY	TIMESCALE FOR IMPLEMENTATION IN FULL
1	This can be anywhere from **24 hours to 4 weeks from the date of the inspection** – the specific date for implementation in full will be specified
2	Up to **3 months** from the date of the inspection
3	Up to **6 months** from the date of the inspection

[i] http://www.healthcareimprovementscotland.org/his/idoc.ashx?docid=428975a9-70aa-4c05-b843-1f0f75ab9473&version=-1

HSC Trust Quality Improvement Plan

WARD NAME	**Lissan 1**	**WARD MANAGER**	**Wilma Thom**	**DATE OF INSPECTION**	**30 May – 1 June 2016**
NAME(S) OF PERSON(S) COMPLETING THE IMPROVEMENT PLAN	Patricia Heatley	**NAME(S) OF PERSON(S) AUTHORISING THE IMPROVEMENT PLAN**		Dr Tony Stevens, Chief Executive	

Recommendations are made in accordance with The Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS, 2006.

The areas where improvement is required, as identified during this inspection visit, are detailed in the Inspection Report and Quality Improvement Plan (QIP).

The completed QIP should be completed and returned to team.mentalhealth@rqia.org.uk from the HSC Trust approved e-mail address, by 16 August 2016.

Please password protect or redact information where required.

PRIORTY	TIMESCALE FOR IMPLEMENTATION IN FULL
1	This can be anywhere from **24 hours to 4 weeks from the date of the inspection** – the specific date for implementation in full will be specified
2	Up to **3 months** from the date of the inspection
3	Up to **6 months** from the date of the inspection

Part A

Priority 1: Please provide details of the actions taken by the Ward/Trust in the timeframe **immediately** after the inspection to address the areas identified as **Priority 1**.

Area identified for Improvement	Timescale for full implementation	Actions taken by Ward/Trust	Attached Supporting Evidence	Date completed
Key Outcome Area – Is Care Safe? Ligature risks identified within the ward require a clear plan as to how they would be managed to help ensure patient safety. **Minimum Standard: *Quality Standard (5.3.1f).*** This area has been identified for improvement for the **first** time.	1 July 2016	An action plan has been devised on how to manage the ligature risks identified. A schedule of works has been put in place in collaboration with Estate services. The ligature work scheduled will be commenced on 15 August 2016 to be completed on 19 August 2016.	Schedule of works attached	
Key Outcome Area – Is Care Effective? There was no clear action plan to deal with the efficient discharge/transfer of patients who no longer meet the grounds for admission to a PICU environment. **Minimum Standard: *Quality Standard 5.3.3(b).***	1 July 2016	The management of patients in the Trust's Psychiatric wards complies with the Regional Bed Management Protocol. This means that patients may on occasion be accommodated in PICU when they do not require this level of support. A protocol has been devised for the Bed Management Team and Lissan 1 team to identify and prioritise transfer arrangements for patients exiting PICU.	The protocol to manage transfers is attached and tracking form to support audit.	

This area has been identified for improvement for the **first** time.		An auditable tracking mechanism has been put in place to support the monitoring of this process		
Key Outcome Area – Is Care Compassionate? None of the areas for improvement identified as a result of this inspection are required to be completed within this area.		No action required		
Key Outcome Area – Is the Service Well Led? None of the areas for improvement identified as a result of this inspection are required to be completed within this area.		No action required		

Part B

Priority 2: Please provide details of the actions proposed by the Ward/Trust to address the areas identified for improvement. The timescale within which the improvement must be made has been set by RQIA.

Area identified for improvement	Timescale for improvement	Actions to be taken by Ward	Attached Supporting Evidence	Date completed
Key Outcome Area – Is Care Safe?	1 September 2016	The ligature work schedule will be commenced on 15 August 2016 and completed by 19 August 2016, per contractors	Attached work schedule	

The work required to remove or replace ligature risks had not been commenced. **Minimum Standard: *Quality Standard (5.3.1f).*** This area has been identified for improvement for the **first** time.				
Key Outcome Area – Is Care Effective? None of the areas for improvement identified as a result of this inspection are required to be completed within this priority.		No action required		
Key Outcome Area – Is Care Compassionate? None of the areas for improvement identified as a result of this inspection are required to be completed within this priority.		No action required		
Key Outcome Area – Is the Service Well Led? None of the areas for improvement identified as a result of this inspection are required to be completed within this priority.		No action required		

Part C

Priority 3: Please provide details of the actions proposed by the Ward/Trust to address the areas identified for improvement. The timescale within which the improvement must be made has been set by RQIA.

Area identified for improvement	Timescale for improvement	Actions to be taken by Ward	Attached Supporting Evidence	Date completed
Key Outcome Area – Is Care Safe? The CCTV monitor used to support patients in the seclusion room required split screen capability to allow staff to monitor all areas. **Minimum Standard: *Quality Standard (5.3.1f).*** This area has been identified for improvement for the **first** time.	1 December 2016	This work was commenced on 3 August 2016 and was completed on 8 August 2016.		
Key Outcome Area – Is Care Effective? An audit of the transfer/discharge arrangements for patients is required. This will help demonstrate improvement. **Minimum Standard: *Quality Standard 5.3.3(b).***	1 December 2016	A protocol and auditable tracking form has been developed to support improvement, see attached		

This area has been identified for improvement for the **first** time.				
Key Outcome Area – Is Care Compassionate? None of the areas for improvement identified as a result of this inspection are required to be completed within this area.		No action required		
Key Outcome Area – Is the Service Well Led? None of the areas for improvement identified as a result of this inspection are required to be completed within this priority.		No action required		

TO BE COMPLETED BY RQIA

Inspector comment (delete as appropriate)	**Inspector Name**	**Date**
I have reviewed the Trust Improvement Plan and I am satisfied with the proposed actions or I have reviewed the Trust Improvement Plan and I have requested further information	Alan Guthrie	5 september 2016
I have reviewed additional information from the Trust and I am satisfied with the proposed actions		

The **Regulation** and
Quality Improvement
Authority

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