The Regulation and Quality Improvement Authority

RQIA

Mental Health and Learning Disability

Unannounced Inspection

Tobernaveen Centre

Holywell Hospital

Northern Health and Social Care Trust

29 & 30 January 2015

npm national preventive mechanism

informing and improving health and social care
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Contents

1.0 General Information

Ward Name	Tobernaveen Centre
Trust	Northern Health and Social Care Trust
Hospital Address	Holywell Hospital 60 Steeple Road Antrim BT41 2RJ
Ward Telephone number	028 94465211
Ward Manager	Deirdre Convery
Email address	deirdre.convery@northerntrust.hscni.net
Person in charge on day of inspection	Deirdre Convery
Category of Care	Acute admission ward for patients over 65 with mental health problems
Date of last inspection and inspection type	18 November 2013
Name of inspector(s)	Audrey McLellan

2.0 Ward profile

Tobernaveen Centre is a 14 bedded acute admission ward on the Holywell hospital site. The purpose of the ward is to provide care and treatment to patients over the age of 65 who have mental health problems. The multi-disciplinary team consists of a full-time consultant, a senior house officer, a part time specialist registrar, nursing staff, two part time occupational therapists, a social worker, a pharmacist and health care assistants

On the days of the inspection there were 14 patients on the ward and four of these patients had been detained in accordance with the Mental Health (Northern Ireland) Order 1986. There were no patients on leave on the day of the inspection and there was one patient whose discharge was considered as delayed. There were four male patients and seven female patients on the ward on the days of the inspections.

The ward was an open ward and patients were observed leaving the ward to go for walks around the hospital site. The ward displayed information in relation to the advocacy service and the complaints process, information in relation to services that may benefit the patients on the ward, and information for carers on support groups in the area.

The ward had an occupational therapy room, two recreational rooms and a kitchen and dining room which had a vending machine. Patients sleeping areas consisted of three bedded bay areas and single rooms with ensuite. The ward environment appeared homely and welcoming.

3.0 Introduction

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of Northern Ireland's health and social care services. RQIA was established under the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, to drive improvements for everyone using health and social care services. Additionally, RQIA is designated as one of the four Northern Ireland bodies that form part of the UK's National Preventive Mechanism (NPM). RQIA undertake a programme of regular visits to places of detention in order to prevent torture and other cruel, inhuman or degrading treatment or punishment, upholding the organisation's commitment to the United Nations Optional Protocol to the Convention Against Torture (OPCAT).

3.1 Purpose and Aim of the Inspection

The purpose of the inspection was to ensure that the service was compliant with relevant legislation, minimum standards and good practice indicators and to consider whether the service provided was in accordance with the patients' assessed needs and preferences. This was achieved through a process of analysis and evaluation of available evidence.

The aim of the inspection was to examine the policies, procedures, practices and monitoring arrangements for the provision of care and treatment, and to determine the ward's compliance with the following:

- The Mental Health (Northern Ireland) Order 1986;
- The Quality Standards for Health & Social Care: Supporting Good Governance and Best Practice in the HPSS, 2006
- The Human Rights Act 1998;
- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003;
- Optional Protocol to the Convention Against Torture (OPCAT) 2002.

Other published standards which guide best practice may also be referenced during the inspection process.

3.2 Methodology

RQIA has developed an approach which uses self-assessment, a critical tool for learning, as a method for preliminary assessment of achievement of the inspection standards.

Prior to the inspection RQIA forwarded the associated inspection documentation to the Trust, which allowed the ward the opportunity to

demonstrate its ability to deliver a service against best practice indicators. This included the assessment of the Trust's performance against an RQIA Compliance Scale, as outlined in Section 6.

The inspection process has three key parts; self-assessment, pre-inspection analysis and the visit undertaken by the inspector.

Specific methods/processes used in this inspection include the following:

- analysis of pre-inspection information;
- discussion with patients and/or representatives;
- discussion with multi-disciplinary staff and managers;
- examination of records;
- consultation with stakeholders;
- file audit; and
- evaluation and feedback.

Any other information received by RQIA about this service and the service delivery has also been considered by the inspector in preparing for this inspection.

The recommendations made during previous inspections were also assessed during this inspection to determine the Trust's progress towards compliance. A summary of these findings are included in section 4.0, and full details of these findings are included in Appendix 1.

An overall summary of the ward's performance against the human rights theme of Autonomy is in Section 5.0 and full details of the inspection findings are included in Appendix 2.

The inspector would like to thank the patients, staff and relatives for their cooperation throughout the inspection process.

4.0 Review of action plans/progress

An unannounced inspection of Tobernaveen Centre was undertaken on 29 & 30 January 2015.

Since the last inspection it was good to note that the ward had piloted a new approach to administrating medication as part of releasing time to care called the 'Person Centred Approach to Administration of Medication'. The aim of this approach is to move away from a task-orientated activity to a person centred engagement with the patient. Each member of staff (preferably the named nurse) was responsible for ensuring medication was administrated to a set number of patients each day. This gave the nurse the opportunity to engage with the patient, assess the patient's ability to take their medication and to discuss the reasons why they are on each medication.

Two part-time occupational therapists had been recruited to work on the ward. There was evidence in the three sets of care documentation reviewed by the inspector that patients had been referred on admission to occupational therapy and assessments had been completed. From these assessments an individual timetable had been set up for each patient and patients had received a copy of the timetable. There was evidence in the progress notes that the occupational therapists had monitored patient's participation in activities. Activities included ward based activities and activities which were held in the OT villa on the hospital grounds, the OASIS in the main hospital building and in the community. The occupational therapist department had access to a people carrier and one evening in the week patients availed of a leisure evenings in the community. The ward was an open ward and patients were encouraged to walk around the hospital site with staff and unaccompanied when this had been agreed at the multi-disciplinary zoning meetings.

4.1 Review of action plans/progress to address outcomes from the previous announced inspection

The recommendations made following the last announced inspection on 18 November 2013 were evaluated. The inspector was pleased to note that all nine recommendations had been fully met and compliance had been achieved in the following areas:

- Advocates facilitate the patient meetings and minutes are documented showing issues raised/action taken and outcomes.
- All staff had attended complaints training
- Two part-time occupational therapists are now working on the ward
- Regular staff meetings are held which detail issues raised/action taken and outcomes
- Care plans were individualised and person centred
- Staff had attended training on managing challenging behaviour
- There is now a full time social worker allocated to the ward

4.2 Review of action plans/progress to address outcomes from the patient experience interview inspection

There were no recommendations made following the patient experience interview inspection on 21 May 2014.

4.3 Review of action plans/progress to address outcomes from the previous finance inspection

The recommendations made following the finance inspection on 2 January 2014 were evaluated. The inspector was pleased to note that two recommendations had been fully met and compliance had been achieved in the following areas:

- The ward manager ensures that all items brought into the ward are recorded and if items are removed by relatives this is also recorded in the patients care documentation
- The ward manager ensures that records are kept of the withdrawals made by patients at the cash office

One recommendation could not be assessed as the ward no longer completes this task.

Despite assurances from the Trust, one recommendation had not been fully met. One recommendation will require to be restated for a second time in the Quality Improvement Plan (QIP) accompanying this report.

Details of the above findings are included in Appendix 1.

5.0 Inspection Summary

The following is a summary of the inspection findings in relation to the Human Rights indicator of Autonomy and represents the position on the ward on the days of the inspection.

The inspector reviewed three sets of care documentation and there was evidence that patients' capacity to consent to their care and treatment had been monitored and evaluated regularly on the ward. This was evidenced throughout the nursing and medical notes, occupational therapy progress reports and the multi-disciplinary team zoning meetings. There was evidence in one set of care documentation reviewed, that the patient's capacity had been assessed and the outcome was that the patient did not have the capacity to make decisions regarding their care and treatment. A 'best interest' multi-disciplinary meeting had been held with the patient's family to discuss the patient's future care and treatment.

In one set of care documentation reviewed the progress notes indicated that on occasions the patient was non-compliant with taking their medication. However there was no care plan in place to indicate how this was managed on the ward. A recommendation has been made in relation to this

After each zoning meeting on the ward the patients were met by the consultant and the senior house officer to discuss the outcome of the zoning meeting and what actions had been agreed. This was recorded on the zoning meeting template and care plans were updated from the zoning meeting if required. These meetings were recorded in the zoning meeting template under the heading 'This care plan has been discussed with the patient' with a section for the nurse on the ward to sign and date. However there was no record of the patient's views and if they agreed to the treatment plan. A recommendation has been made in relation to this.

There was evidence in the nursing progress notes in the three sets of care documentation reviewed by the inspector that patients had been given time to discuss their care and treatment. Patients received one to one sessions with a member of the nursing staff each day to discuss their care and treatment plans. They had an opportunity at these meetings to discuss any concerns and worries they may have and the staff were able to assess the patient's mental health. In the three sets of care documentation reviewed there were detailed records of these meetings which were held daily.

The consultant on the ward worked full time on the ward alongside a senior house officer and a part-time registrar. If patients or family members requested a meeting with the doctor this was arranged on the ward. There was evidence in the patients care documentation that patients had met with the doctor on the ward to discuss various different aspects of their care and treatment and meetings had been held with patients and their family members.

The inspector met with four patients on the ward and all four patients were able to describe how they had met with the doctors and nurses on the ward to discuss their care and treatment. All four patients were able to describe the treatment plan that was in place for them and how they had been consulted prior to any treatment plan commencing.

In the 21 questionnaires returned by staff members on the ward prior to the inspection, four indicated that they had received training in relation to capacity and consent and six indicated that they had received training relating to human rights. A recommendation has been made in relation to this.

The inspector spoke to six staff members on the ward which included nursing staff, the ward consultant and the occupational therapist. All six members of staff demonstrated their knowledge of capacity to consent and informed the inspector of the steps they took to gain the patients consent.

All nine questionnaires returned by patients' relatives/carers prior to the inspection indicated that they and their relative had been offered the opportunity to be involved in their care and treatment on the ward

The inspector reviewed three sets of care documentation and there was evidence that patients and their carers/relatives had been involved in holistic needs assessments and had been involved in developing their care plans. In all three sets of care documentation, the patients had a 'Generic Integrated Care Pathway for Acute Admission Wards' completed. Zoning multi-

disciplinary meetings were held daily for some patients on the ward and weekly for other patients depending on their individual needs. There was evidence that care plans had been devised from the outcome of zoning meetings and action/outcomes were agreed for each patient. However in all three sets of care documentation reviewed the zoning meeting templates were inconsistently complete with sections missing. A recommendation has been made in relation to this.

Care plans in the three sets of care documentation reviewed evidenced that patients had been involved in these plans as each patient had signed that they had agreed with the care plans in place. However there was no indication in the care documentation of when these plans were reviewed. A recommendation has been made in relation to this.

Progress notes by the nursing staff indicated ongoing monitoring of the patient's care in relation to each individual care plan. A record of the number of the care plan was recorded next to the record of the patient's progress in relation to this care plan as agreed in the guidelines for completion of this document. However the progress records reviewed by the inspector indicate that this method of recording was inconsistent throughout the care documentation reviewed. Nursing staff had not indicated on occasions which care plan they were recording progress against and therefore records were not completed in accordance with the recommended guidelines. A recommendation has been made in relation to this.

It was good to note that in all three sets of care documentation reviewed care plans were in place which included core care plans that had sections added and individualised person centred care plans. However, in all three sets of care documentation reviewed, assessments had indicated areas that a care plan was required to meet the assessed need, but these had not be developed. A recommendation has been made in relation to this.

There was evidence in the three sets of care documentation reviewed that a risk screening tool had been completed for each patient and reviewed regularly. However in the three sets of care documentation there was no indication of the 'further action necessary' or who had received a copy of the assessment. In two out of the three sets of care documentation the patients had not signed the screening tool and there was no indication of why this was not signed. A recommendation has been made in relation to this.

The inspector noted a profiling bed was being used by one patient on the ward as this patient had a physical condition and therefore needed this type of bed. The ward manager was aware that in December 2013 the Health and Social Care Board requested that all HSC Trusts take appropriate actions in accordance with The Northern Ireland Adverse Incident Centre Estates and Facilities Alert EFA/2010/006 and therefore all profiling beds had been removed from the ward apart from the one needed for this individual patient. However there was no individual risk assessment in place for the use of this bed for this individual patient. A recommendation has been made in relation to this.

Although it is good to note that there was only one of these types of beds available on the ward for one individual patient who had been assessed as needing this type of bed, there were risks associated with ligature points for other patients on the ward. The matter was brought to the attention of the ward manager and the nursing services manager at the conclusion of the inspection who advised that a risk management plan is in progress to fully implement the requirements of this alert. A recommendation has been made in relation to this

The inspector was informed by the ward manager that the multi-disciplinary team consists of a consultant, a senior house officer (SHO), a specialist registrar (SPR), nursing staff, two part-time occupational therapists, a pharmacist and a social worker. However patients cannot access psychology services as an inpatient. A recommendation has been made in relation to this.

There was evidence in the three sets of care documentation reviewed that patients' communication needs are assessed on admission to the ward by the nursing staff, medical staff and the occupational therapist.

The inspector spoke to four patients on the ward who all informed the inspector that they availed of activities with the occupational therapist on the ward. One patient stated that it helped to 'split up the day' and they were able to meet other patients from different wards. Another patient talked about the items they had made in the craft class and how they enjoyed doing something 'useful'.

There were four patients detained on the ward in accordance with the Mental Health (Northern Ireland) Order 1986. The inspector reviewed two sets of care documentation whereby the patients had been detained. There was evidence available to confirm that these patients had been informed of their rights in relation to the detention process and information about the Mental Health Review Tribunal, and how to make a referral to the Mental Health Review tribunal. There was evidence in the care documentation that staff had discussed this process with patients when having one to one individual time with patients. However this information was not available in a suitable format for each patient's individual communication needs. A recommendation has been made in relation to this.

Information was displayed throughout the ward on the complaints procedure, the Mental Health (Northern Ireland) Order, the Human Rights Act and the advocacy service. An independent advocate from NIAMH facilitated patient meetings on the ward. The inspector reviewed minutes of patient meetings and there was evidence that meetings were held on the ward with active engagement from patients

The ward had an information leaflet available for patients to read which detailed the role of the multi-disciplinary team, items that were restricted on the ward, the use of personal lockers, the detention process, meals, visiting

times, occupation therapy programmes and contact details of the Citizens Advice Bureau and the Mental Health Review Tribunal

There was evidence in the zoning meetings, care plans and in the patient's progress notes reviewed by the inspector that patients' Article 5 rights to liberty and security of person, Article 8 rights to respect for private and family life and Article 14 right to be free from discrimination have been considered.

The inspector met with two health care workers and two staff nurses on the ward to discuss deprivation of liberty on the ward. Staff spoke about patients being deprived of their liberty on the ward as some patients are detained under the Mental Health (Northern Ireland) Order 1986 and therefore are unable to leave the ward unless an agreement has been reached by the multi-disciplinary team. Staff discussed how restrictive practices are reviewed at the multi-disciplinary ward round and when patients are well enough to be restated to voluntary status this is implemented as soon as possible. It was good to note that 17 out of the 21 questionnaires returned from staff prior to the inspection indicated that they had received training in relation to restrictive practice.

In the three sets of care documentation reviewed by the inspector, there was evidence of core care plans in place for the patients who had been detained in accordance with the Mental Health (Northern Ireland) Order 1986 and in relation to Article 8 rights to respect for private & family life. However, there were no individual restrictive practice care plans in place in relation to other restrictions on the ward such as patients' access to personal monies, restricted items and the potential use of physical intervention. A recommendation has been made in relation to this.

There was evidence in one set of care documentation reviewed by the inspection that a patient was going to be discharged to a nursing home. This had been discussed at the multi-disciplinary zoning meetings with the outcome agreed that the nursing home staff were to come to the ward to complete an assessment. Discharge planning meeting had also been held with the patient and their family to discuss this process. The ward manager advised the inspector that when patients are discharged into a nursing home they are initially on two weeks leave from the ward and can be readmitted to the ward if issues arise.

The inspector spoke to one patient who was on a phased discharge plan. This patient advised that they had attended a meeting regarding their discharge with their family and they had had day passes and overnight passes home. This patient stated they were happy with the plans that had been put in place and stated they felt fully involved in the process. They had initially been very reluctant to be discharged home as they felt they would not have been able to cope and they were happy with how staff had listened to their concerns.

The ward manager advised that a social worker is based on the ward and they link in with the community teams to gather information regarding patients'

social history and promoting quality care risk assessments. They also link in with the family members and nursing home depending on the plan for each patient. If care packages are needed in the community, the social worker will link in with the keyworker in the community to ensure this is in place before the patient is discharged

There was evidence in the files of 'summary of admission on discharge' forms completed and 'discharge care plans' in place. The ward manager links in with the team leader in the community prior to the patients discharge into the community to set up a follow up appointment with the keyworker within seven days so that the patient has a follow up date prior to their discharge. The ward manager gives the patient an appointment card which details the patients follow up appointment which can either be in the clinic or in the patients' own home.

The ward manager advised that there was one patient on the ward whose discharge was considered delayed. All delayed discharged are reported to the Health and Social Care Board.

Throughout the care documentation reviewed by the inspector there was evidence that patients' Article 8 rights to respect for private and family life & Article 14 right to be free from discrimination had been considered.

Details of the above findings are included in Appendix 2.

On this occasion Tobernaveen Centre has achieved an overall compliance level of substantially compliant in relation to the Human Rights inspection theme of "Autonomy".

6.0 Consultation processes

During the course of the inspection, the inspector was able to meet with:

Patients	**4**
Ward Staff	**4**
Relatives	**0**
Other Ward Professionals	**2**
Advocates	**1**

Patients

All four patients informed the inspector that they knew why they were in hospital and knew what they could and could not do on the ward. All four patients stated they had been involved in their care and treatment and were able to involve their family members when they wanted to involve them. They all advised that the nurses and doctors had spoken to them about their illness and their medication. One patient stated that they had spoken to the doctors on the ward and they were "both lovely". They advised that their medication had been increased and that they had attended the general hospital for a chest x-ray and were now on new tablets. This patient stated that their husband and daughter had also spoken to the doctor. Another patient stated that their family members were not involved in their care and treatment as they had asked for them not to be involved. One patient stated that they were going for a new treatment next week called ECT. They advised that the doctors had explained this procedure to them and they were not looking forward to this but hoped it would help them. All four patients informed the inspector that they had felt safe on the ward. They had all heard of the advocate on the ward and had attended meetings which had been held. When discussing their overall care and treatment on the ward patients made the following statements:

"I can go off the ward when I want. I went out with my husband last Saturday. I went home and to the hairdressers, it was lovely. I think the care is great, staff are well mannered and don't treat you like an old lady. They come in and have a chat".

"Been good"

"Nurses have been fine"

"The care is good here"

Relatives/Carers

There were no relatives available on the days of the inspection

Ward Staff

The inspector met with two nurses on the ward and two health care assistants on the days of the inspection. All staff informed the inspector that they enjoyed working on the ward. The stated that they could see the benefits of the change to the wards function and purpose of providing care and treatment to patients over 65 years with mental health problems. All four staff members were able to describe how they gained consent from patients to attend to their nursing needs on the ward. If patients refused they advised that they respected the patients' decision and would try to encourage them at a later point in the day. The two nurses advised that they had good relationships with all the multi-disciplinary team members on the ward. They both stated that they could go to the consultant at any time to discuss patients' needs. One of the nurses on the ward spoke about the new person centred way the ward was administrating patient's medication. They informed the inspector that they felt this was a much better way, as they now have time to sit with patients and discuss their medication. The healthcare workers advised that they assist the occupational therapists on the ward with activities and they also accompany patients out for walks around the grounds and up to the main hospital to the OASIS and the canteen.

Other Ward Professionals

The inspector met with one of the occupational therapists who works on the ward. They advised they enjoyed working on the ward and felt part of the multi-disciplinary team. They described how they monitor patients' progress on the ward and how they update the multidisciplinary team each week. They informed the inspector of all the activities the patients can avail of on and off the ward. They informed the inspector that there were plans in place to move the occupational therapy room to a larger room on the ward and new soft furnishings had been ordered. They informed the inspector that this new furniture will create a much more welcoming environment for patients to attend group activities and even for patients who just want to come along and watch activities taking place.

The inspector met with the consultant who works full time on the ward and they informed the inspector that they were supported by a part-time specialist registrar and a full-time senior house officer. They advised the inspector that patients' capacity is monitored and evaluated on the ward and patients are presumed to have sufficient capacity to decide on their own medical treatment unless there is evidence to suggest otherwise. At this point capacity assessments are undertaking. They advised that 'best interest' meetings had been set up for patients who had been deemed as lacking capacity to make specific decisions. They advised that each week they meet with patients to discuss their care and treatment on the ward.

Advocates

No advocates were available on the days of the inspection

Service user consultant

The inspector met with the wards service user consultant who was employed by the Trust and attends the senior management meetings. They also attend the ward every two weeks to speak to patients. They are employed to bring service users' views forward to the senior management meetings. They informed the inspector that they had previously been an inpatient and therefore they felt they had a greater understanding of what it was like to be a patient on the ward. They advised they were looking at the use of the mobile phone policy and were in the process of producing new guidelines around this restriction on the ward. They advised that the ward had a calm environment, now that there were only patients over the age of 65 admitted onto the ward and they stated that staff seem to have time to sit with patients and chat during the day**.**

Questionnaires

Questionnaires were issued to staff, relatives/carers and other ward professionals in advance of the inspection. The responses from the questionnaires were used to inform the inspection process, and are included in inspection findings.

Questionnaires issued to	Number issued	Number returned
Ward Staff	20	19
Other Ward Professionals	5	2
Relatives/carers	12	9

Ward Staff

There were 19 questionnaires returned from the health care assistants, nurses and the ward manager in advance of the inspection. Information contained within the questionnaires indicated that two ward staff had received training in capacity to consent and four had attended training on human rights. All 19 stated that they were aware of the Deprivation of Liberty Safeguards (DOLS) – interim guidance and 17 staff members indicated they had received training in relation to restrictive practices. Out of the 19 questionnaires returned all 14 ward staff indicated they had received training on meeting the needs of patients who need support with communication and all 19 staff members indicated that patients communication needs were recorded in their assessment and care plans and that they were aware of alternative methods of communicating with patients. They all indicated that these methods were used on the ward. All 19 ward staff reported that the level of therapeutic and recreational activities meets the patients individual needs on the ward.

Other Ward Professionals

There were two questionnaires returned from the speech and language therapist and the ward doctor in advance of the inspection. Information contained within the questionnaires indicated that both professionals had received training in capacity to consent and on human rights. One professional was not aware of the Deprivation of Liberty Safeguards (DOLS) – interim guidance. One professional indicated they had not received training in relation to restrictive practices.

The two ward professionals indicated they had received training on meeting the needs of patients who need support with communication. All three ward professionals indicated that patient's communication needs were recorded in their assessment and care plan. The three ward professionals indicated that they were aware of alternative methods of communicating with patients and stated these methods were used on the ward. The professionals indicated that the level of therapeutic and recreational activities meets the patients individual needs on the ward.

Relatives/carers

Nine questionnaires were returned by relatives/carers in advance of the inspection. It was good to note that six relatives indicated that they felt the care on the ward was excellent and three stated that the care was good. Relatives/carers stated that:

"Staff are always friendly and welcoming. They are happy to answer any queries and to keep me up to date with relevant information regarding my X. They listen to any concerns and have modified plans in response to same"

"Staff are very considerate and meet X's every need"

"I feel my X has been looked after extremely well by all the staff. They have been caring and more than courteous to the both of us"

"Our X has received tremendous nursing care and support from all involved in her care. This admission has provided X with the opportunity to make friends rediscover her social skills and get back her personality. We have been very impressed by the high standards of food and cleanliness. It is reassuring to know that the facility such as Tobernaveen is available to help and care for patients and their family".

"We are not aware of any shortfall in care and attention. Staff, nurses, doctors are excellent"

"My X has received first class care and has improved better than I expected. I can't speak more highly of the nursing staff"

All nine relatives/carers stated that they and their relative had been given the opportunity to be involved in decisions in relation to their care and treatment.

All nine relatives/carers indicated that their relative had an individual assessment completed in relation to therapeutic and recreational activities and five relatives/carers stated that their relative did not participated in activities on the ward.

7.0 Additional matters examined/additional concerns noted

Complaints

The inspector reviewed complaints received by the ward between 1 April 2013 and 31 March 2014. There was one complaint received over this period of time by a relative and had been fully resolved to the satisfaction of the complainant.

8.0 RQIA Compliance Scale Guidance

Guidance - Compliance statements		
Compliance statement	**Definition**	**Resulting Action in Inspection Report**
0 - Not applicable	Compliance with this criterion does not apply to this ward.	A reason must be clearly stated in the assessment contained within the inspection report
1 - Unlikely to become compliant	Compliance will not be demonstrated by the date of the inspection.	A reason must be clearly stated in the assessment contained within the inspection report
2 - Not compliant	Compliance could not be demonstrated by the date of the inspection.	In most situations this will result in a requirement or recommendation being made within the inspection report
3 - Moving towards compliance	Compliance could not be demonstrated by the date of the inspection. However, the service could demonstrate a convincing plan for full compliance by the end of the inspection year.	In most situations this will result in a recommendation being made within the inspection report
4 - Substantially Compliant	Arrangements for compliance were demonstrated during the inspection. However, appropriate systems for regular monitoring, review and revision are not yet in place.	In most situations this will result in a recommendation, or in some circumstances a recommendation, being made within the Inspection Report
5 - Compliant	Arrangements for compliance were demonstrated during the inspection. There are appropriate systems in place for regular monitoring, review and any necessary revisions to be undertaken.	In most situations this will result in an area of good practice being identified and being made within the inspection report.

Appendix 1 – Follow up on Previous Recommendations

The details of follow up on previously made recommendations contained within this report are an electronic copy. If you require a hard copy of this information please contact the RQIA Mental Health and Learning Disability Team:

Appendix 2 – Inspection Findings

The Inspection Findings contained within this report is an electronic copy. If you require a hard copy of this information please contact the RQIA Mental Health and Learning Disability Team:

Contact Details
Telephone: 028 90517500
Email: Team.MentalHealth@rqia.org.uk

Appendix 1

Follow-up on recommendations made following the announced inspection on 18 November 2013

No.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	It is recommended that the ward manager ensures that advocates are invited to attend the monthly patient meetings and are proactive in engaging with patients.(2)	The inspector reviewed minutes of patient meetings and there was evidence that meetings were held each month on the ward. Minutes of these meetings showed a record of those in attendance and matters arising. The ward manager advised that patient meetings are facilitated by an independent advocate from NIAMH and this has been working well with active engagement from patients.	Fully met
2	It is recommended that the ward manager ensures patient meetings are held and documented showing issues raised/action taken and outcomes (2)	The inspector reviewed minutes of patient meetings and there was evidence that meetings were held each month on the ward. Minutes of these meetings detailed issues raised any action taken with outcomes.	Fully met
3	It is recommended that the ward manager ensures all staff attend complaints training. (2)	The inspector reviewed the training matrix and there was evidence that all staff on the ward had attended complaints training.	Fully met
4	It is recommended that the Trust review the current occupational therapy service to the ward as a matter of urgency (2)	The Trust has recruited two part-time occupational therapists to work on the ward with some extra cover provided by an occupational therapist assistant.	Fully met
5	It is recommended that the ward manager ensures regular staff meetings are held and documented with issues raised/ action taken and outcomes.(1)	Daily briefings are held on the ward each day with staff. Issues discussed include: Pending Admissions, Number of Observations, Outstanding Patient Care, Safeguarding, Infection Control, Safety, Accidents/Incidents, Reflection, Estates, Staffing, Courses/Training, Policies and Any Other Business. The ward manager also holds quarterly team meetings. The inspector reviewed the minutes of these meetings and issues raised/action taken and outcomes had been recorded.	Fully met

6	It is recommended that the ward manager ensures that care-plans are person-centred and individualised.(1)	The inspector reviewed care plans in three sets of care documentation and there was evidence that care plans were person centred and individualised. However assessments had been completed for patients and care plans had not been devised from each assessed area of need. A new recommendation will be made in relation to this.	Fully met
7	It is recommended that the ward manager ensures that all staff have attended training in managing challenging behaviour. (1)	All staff working on the ward had received training on MAPA. Three staff members who had been on longer term sick leave and had missed the set training sessions. However dates have been set up for these members of staff to receive up to date training in February and March 2015.	Fully met
8	It is recommended that the Trust adheres to the ethos of the ward and does not admit patients with dementia or young adults. (1)	Tobernaveen is an acute admission ward for patients over 65 who have a mental health problem. However on occasions patients may be admitted onto the ward and when assessments are completed it is discovered that they have a dual diagnosis of dementia and a functional mental illness. These patients are treated on an individual basis and links are made with the dementia ward to discuss where the patient's needs would be best met on the Holywell site. This can mean that these patients will continue to be nursed in the Tobernaveen ward.	Fully met
9	It is recommended that the Trust review social work arrangements for the ward to ensure adequate support is given to patients.(1)	The Trust has recruited a full time social worker to work on Avoca ward.	Fully met

Appendix 1

Follow-up on recommendations made following the patient experience interview inspection on 21 May 2014

No.	Reference.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	N/A	N/A	N/A	N/A

Follow-up on recommendations made at the finance inspection on 2 January 2014

No.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	It is recommended that the ward manager ensures that all items brought into the ward on admission that are removed by relatives are recorded. Record of receipt by the relative should be obtained.	All patients property is recorded when they are admitted onto the ward and patients receive a copy of this record. If relatives remove any items from the patient they are encouraged to advise a staff member of this so that this can be recorded in the patients care documentation that these items have been removed. Notices are displayed throughout the ward advising relatives of this arrangement.	Fully met
2	It is recommended that the ward manager ensures that records are kept at ward level of the withdrawals made by patients from the cash office.	A record book is kept on the ward of withdrawals made by patients on the ward and this is signed by two members of staff. Patients also sign this book when they receive their money.	Fully met
3	It is recommended that the ward manager ensures that individual patient statements are received from the cash office in order to verify that transactions are correct.	Individual statements are not received from the cash office. The ward manager advised that if patients request a statement they can arrange this with the cash office. However to date this is not been implemented on the ward This recommendation will be restated for a second time .	Not met
4	It is recommended that the ward manager ensures that a system to verify clothes and other items purchased for patients are checked by ward staff against the receipt, confirmed as received by the patient and	This practice no longer takes place on the ward as the function of the ward has changed to patients being admitted who are over 65 and have a mental health problem. The ward manager informed the inspector that these patients predominantly ask	Not assessed

	receipts retained.	their relatives/carers to purchase items for them. However the ward manager advised that if patients did want to purchase clothes or any other items they would set up a record book to check purchases against receipts and ask patients to sign that they have received the items and they would retained the receipt.	

Follow up on the implementation of any recommendations made following the investigation of a Serious Adverse Incident

No.	SAI No	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	N/A	N/A	N/A	N/A

Quality Improvement Plan

Unannounced Inspection

Tobernaveen Centre, Holywell Hospital

29 & 30 January 2015

The areas where the service needs to improve, as identified during this inspection visit, are detailed in the inspection report and Quality Improvement Plan.

The specific actions set out in the Quality Improvement Plan were discussed with the ward manager, the service manager and the consultant on the ward on the day of the inspection visit.

It is the responsibility of the Trust to ensure that all requirements and recommendations contained within the Quality Improvement Plan are addressed within the specified timescales.

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
1	5.3.1 (f)	It is recommended that the ward manager ensures that individual patient statements are received from the cash officer in order to verify that transactions are correct.	2	31 March 2015	Where a patient lacks capacity to manage their finances the Ward Manager can access all Cash Transactions with the Cash Office. The Cash Office will send statements as required to the Ward Manager when requested.
2	5.3.1 (a)	It is recommended that the ward manage ensures care plans are in place to direct patients care when they do not give consent to care and treatment on the ward.	1	31 March 2015	All Care Plans are individualised to the patient's needs. Care Plans will reflect when a patient does not give consent. Recovery Focused Care has been provided to staff in regard to Care Planning. The Ward Manager has worked individually with the Multi-Disciplinary Team to ensure that Care Plans are person-centred and individualised.
3	5.3.3 (b)	It is recommended that the ward manager reviews how they record the outcome of multi-disciplinary zoning meetings to ensure there is a record of patients views regarding their treatment plan.	1	31 March 2015	The ward Manager has worked individually with the Multi-Disciplinary Team to ensure that the Zoning Meetings have a record of patient's views regarding their Treatment Plans.

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
					The Template has been revised to ensure patients views are recorded and these will be used for all zoning meetings from week commencing 13 April 2015. In the interim the Doctor will write in the Zoning Sheet the patient's views regarding their Treatment Plan.
4	4.3 (m)	It is recommended that the ward manager ensures that all staff on the ward receive training in relation to human rights and capacity to consent.	1	31 May 2015	At present Human Rights and Capacity Training is ongoing. Trained Staff is at 60% and Untrained Staff is at 54% with the emphasis being that all staff will have received training when more training dates become available, these are presently being sourced and will be delivered in April & May.
5	5.3 1 (f)	It is recommended that the ward manager ensures that each section on the template for the multi-disciplinary zoning meeting is complete in full	1	Immediate and ongoing	The Ward Manager has worked individually with all the members of the Multi-Disciplinary Team in regard to the importance of correct documentation in completing the Zoning Records.
6	5.3.3 (b)	It is recommended that the ward manager ensures care plans are reviewed regularly by the multi-disciplinary team with the	1	Immediate and ongoing	Processes are in place that Care plans are reviewed regularly and patients are involved in this process. A new care Plan template indicating Care

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
		involvement of the patients and that this is recorded in the patients care documentation.			Plan Review has been developed and is in use in the Integrated Care Pathway
7	5.3.1 (f)	It is recommended that the ward manager ensures that all staff follow the 'generic integrated care pathway for acute admission wards' guidelines when completing progress notes for each patient ensuring that progress is recorded against each individual care plan.	1	Immediate and ongoing	All staff are aware of the process of the Generic Integrated Care Pathway for Acute Admission Wards. All Staff are aware of recording at each individual Care Plan and the importance of ensuring that Care Plans are individualised and Person-Centred. This has been discussed at Staff Meetings and Staff Supervision.
8	5.3.1 (a)	It is recommended that the ward manager ensures that when assessments are completed indicating a specific need/problem area, a care plan is completed for each assessed need indicating how this is going to be managed and reviewed on the ward.	1	Immediate and ongoing	All Care Plans reflect each individual problem and this is evident in the Individualised Care Plans. Where an assessment has been made indicating a specific problem the Care Plan will reflect the management of the problem andhow the problem is reviewed at ward level.
9	5.3.1 (a)	It is recommended that the ward manager ensures that when staff complete the risk screening tool	1	Immediate and	All Staff are aware of the importance of completing the Risk Screening Tool. All staff are aware of the importance of carrying out Risk Screening and

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
		they complete this in accordance with the Promoting Quality Care-Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services May 2010		ongoing	assessments with the Multi-Disciplinary Team. All staff are doing Promoting Quality Care E-Learning and are aware of the necessity and importance of good documentation. The expectation is that all staff will have PQC Trainining completed by Mid-April 2015..
10	5.3.1 (c ,f)	It is recommended that the ward managers ensures that when patients are assessed as requiring a profiling bed that a risk assessment is completed for each individual patient and reviewed regularly in accordance with the safety alert raised on 23/12/13 by the Northern Ireland Adverse Incident Centre (NIAC) Estates Facilities Alert /2010/006 associated with profiling beds.	1	Immediate and ongoing	Currently a Risk Management Plan is in progress to fully implement the requirements of the NIAC EFA/2010/006. All patients are Risk Assessed if they require a Profile Bed for Physical Needs. Any Patient who requires a profile Bed will be nursed in a room on their own.
11	6.3.1 (a)	It is recommended that the Trust reviews psychology input to the ward to ensure patients are receiving adequate support when	1	31 July 2015	Nursing staff have been trained in psychological therapies such as Anxiety Management , Dealing with Depression, Attachment Disorder Training and

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
		an inpatient on the ward.			the Wrap Programme. The Psychology Department will provide a service to patients where this has been identified as appropriate. A pre-discharge assessment from the Psychology Department will be provided prior to discharge.
12	6.3.2. (c)	It is recommended that the ward manager ensures that information with regard to patients' rights is available in a suitable format for patients on the ward	1	31 May 2015	All patients receive information both in written and in verbal form. This has always been in place for the patients. The Hospital Advocate is available at any time for patients to speak to and patients are encouraged to approach staff at any time if they have any concerns about the Detention Process. The Hospital Advocates call to the Ward regularly to see new patients. The Hospital Advocates will also chair Patient Meetings on a monthly basis and minutes of all meetings are recorded
13	5.3.1 (a)	It is recommended that the ward	1	Immediate	Deprivation of Liberty Care Plans are in place for

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
		manager ensures that when restrictive practices are in place, individualised care plans are developed detailing the rationale for the level of restriction in terms of necessity and proportionality. Care interventions aimed at in reducing levels of restriction should also be included.		and ongoing	each patient detailing any necessary restrictions and include interventions to reduce levels of restriction on an individual basis. All Deprivation of Liberty Care Plans are individualised and person-centred in accordance with the DOLS Interim Guidance (2010).

NAME OF WARD MANAGER COMPLETING QIP	Deirdre Convery
NAME OF CHIEF EXECUTIVE / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Dr Tony Stevens

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

Inspector assessment of returned QIP				Inspector	Date
		Yes	No		
A.	Quality Improvement Plan response assessed by inspector as acceptable	x		Audrey McLellan	**30/3/15**
B.	Further information requested from provider				