Mental Health Inpatient Inspection Report
21 – 23 February 2017

Tobernaveen Centre

Acute Psychiatric Admission
Holywell Hospital
60 Steeple Road
Antrim
BT41 2RJ

Tel No: 028 94413105
Inspectors: Alan Guthrie, Dr Brian Fleming and Anne Simpson

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

1.0 What we Look For

2.0 Profile of Service

Tobernaveen Centre is a 20 bedded acute admission ward located on the Holywell Hospital site, Antrim. The purpose of the ward is to provide care and treatment to patients over the age of 18, including the provision of 14 beds for patients over the age of 65, who have mental health problems. The ward is supported by two multi-disciplinary teams which include: a Consultant Psychiatrist, nursing staff, an Occupational Therapist, a Social Worker, a Pharmacist and health care assistants.

On the days of the inspection there were 20 patients on the ward. Six patients had been detained in accordance with the Mental Health (Northern Ireland) Order 1986.

The ward's layout included sleeping areas consisting of three bedded bay areas and single rooms with ensuite facilities. The ward also had an occupational therapy room, two recreational rooms, a kitchen and dining room.

3.0 Service Details

Responsible person:	Mr. Tony Stevens, Chief Executive
Ward manager:	Deirdre Convery
Person in charge at the time of inspection: Deirdre Convery	

4.0 Inspection Summary

An unannounced inspection of Tobernaveen Centre took place over three days on 21- 23 February 2017.

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.

We assessed if Tobernaveen Centre was delivering, safe, effective and compassionate care and if the service was well led

Evidence of good practice

- Patients stated they had positive relationships with staff.
- The ward's management team had implemented an effective strategy to address short term nursing staff shortages.
- Nursing staff had responded positively to changes within the ward including the introduction of a new patient group and an increase in the number of beds.
- Staff stated they felt supported and that they enjoyed working on the ward.
- The ward's safeguarding procedures were comprehensive and consistently monitored by ward staff and the hospital's safeguarding team.
- Patients could access the range of professionals required to support their recovery.

- Staff continued to address the ward's environmental challenges and to make changes were possible to increase patient comfort. This included upgrading the ward's bath and replacing mattresses on the ward's fixed beds.

Areas requiring improvement

Four areas requiring improvement were identified and one previous recommendation has been rewritten. These areas for improvement are discussed in the provider compliance plan at the end of this report. One area for improvement is not discussed in the provider compliance plan. This area relates to the ward's environment.

Areas one and two: ward environment

Inspectors were concerned that the layout of the ward presented a number of risk factors including a large number of ligature points. The Trust had addressed this concern and taken action to reduce risk. This included completing a risk ligature management plan and submitting a capital bid to enable the construction of a new purpose built mental health acute admission facility. However, the ward's ligature risk management plan recorded that over 200 ligature points should be locally managed by nursing staff. Inspectors were concerned that where nursing staff could observe and monitor ligature risks, during half hourly checks, the expectation that they actively manage all ligature risks is not possible or realistic. This concern is reflected in the ward's provider compliance plan.

Given that the Trust has continued to proactively address concerns regarding the ward's environment. RQIA has forwarded its inspection findings and associated concerns to the Department of Health. The reason for this action is based on the fact that Tobernaveen Centre ward does not meet environmental best practice standards and the costs involved to address the concerns identified during the inspection would be significant. Based on the evidence and the presenting condition of the ward the Trust's proposed capital bid is the most appropriate option.

Area three: emergency resuscitation equipment

Inspectors evidenced that the ward retained emergency resuscitation equipment and provided emergency response cover to a number of wards within Holywell hospital. Inspectors were concerned that this could negatively impact on patients within Tobernaveen Centre. This is due to the fact that an emergency response required two staff thus leaving the ward understaffed. This issue should be addressed through the provision of emergency resuscitation equipment within each ward.

Area four: The ethos, aim and objectives of the ward

The ward had undergone significant changes during the previous year. Inspectors noted that in June 2016 the ward commenced providing care and treatment to patients under the age of 65. The number of beds available within the ward also increased to 20. Inspectors were concerned that the ethos and aims and objectives of the ward were not clear as the ward had moved from providing care and treatment to patients aged 65 and over, to providing care and treatment to patients from aged 18 and over. Inspectors were unable to clearly identify the care pathways for each patient group.

RQIA will continue to monitor the Trust's progress in these areas.

Five recommendations were made as a result of the previous inspection. It was positive to note that four of the recommendations had been met and one had been partially met. The recommendation that had been partially met has been rewritten. Subsequently, it will be stated for the first time in the provider compliance plan at the end of this report. Inspectors' findings regarding the Trust's progress in addressing these recommendations are discussed in section 6.1 of this report.

Patients Views:

During the inspection inspectors and the lay assessor met with nine patients. Two patients completed a questionnaire. Patients were positive regarding their experience of the ward and were complimentary about the ward staff and their relationships with the multi-disciplinary team (MDT). Patient staff interactions observed by RQIA staff evidenced ward staff to be supportive, friendly and caring. Staff demonstrated a high degree of skill during their interactions with both groups of patients within the ward. It was also positive to note that throughout the inspection patients continually presented as relaxed and at ease in their surroundings.

Patients reported no concerns regarding the care and treatment they received during their admission. Patients also stated that when they had a concern or difficulty regarding their care they could discuss this with nursing staff, the MDT and or the ward advocate. Patients informed the lay assessor that they knew who to talk to if they were not happy or had a concern. It was positive to note that patients understood their rights and were confident in their ability to approach ward staff.

Patients stated:

"I feel safe and well cared for".

"Staff are caring, friendly and helpful".

"Very positive experience so far".

"I don't see the Doctor as often as I would like".

"The nursing and medical staff are very good".

"The Occupational Therapist is helpful".

"I don't have a wardrobe".

"I feel safe but sometimes other patients rummage through my stuff".

"Most of the staff are kind but there are a few who are a bit sharp".

"I like the food and my care is excellent".

"I am very happy with my care".

“I really enjoy occupational therapy”.

“The showers are really poor”.

“The staff are very good they look after me”.

Relatives Views:

During the inspection no relatives were available to meet with an inspector. No relative questionnaires were returned post inspection.

Staff Views:

Inspectors met with 12 members of the ward’s MDT. Staff were positive about their role on the ward and the support they received from the MDT. Staff stated that they felt the MDT was inclusive, effective and considered the views of all staff. Staff evidenced good understanding and knowledge regarding the needs of patients admitted to the ward. Nursing staff stated that the ward was very busy and at times stressful. Staff explained that the nursing role required knowledge and skill in both physical and mental health care and the associated treatment interventions. A number of staff reflected on the challenges of managing the contrasting needs and risks of both patient groups cared for in the ward. Staff quoted examples of providing care and treatment to younger patients presenting as with ensuring that confused older patients were kept safe.

Staff stated they were confident in their role and position within the ward and that they understood the needs of both patient groups. Staff informed inspectors that they felt the care and treatment provided to each patient was appropriate and comprehensively discussed and shared between all team members. Inspectors were informed that the MDT were continuing to review and enhance therapeutic interventions and effectiveness as a means to improving patient care pathways and experience. This included ongoing evaluation of treatment and therapeutic interventions and associated outcomes for patients.

The ward was supported by two consultant psychiatrists. One consultant provided support to patients over the age of 65 and the other to those patients under 65. Medical staff stated that they felt the MDT was effective and ward staff were knowledgeable, skilled and patient centred. Working relationships within the MDT were described as very good. Medical staff expressed no concerns regarding the availability of required professions or the quality of care and treatment provided to patients. Challenges for patient care within the ward were discussed. These included the difficulty in securing suitable community accommodation for younger patients. Staff also reflected on the need for a community based support group, in the Newtownabbey area, for people suffering from a personality disorder. Similar groups provided in other Trust areas were described as being effective.

Staff also discussed continued development of the care pathway between the ward and primary and secondary care dementia care services. Staff stated that these developments and any associated challenges, continued to be assessed and addressed as patients present.

None of the staff who met with inspectors reported any concerns regarding their ability to access training, supervision and appraisal. Staff were complimentary regarding the leadership within the ward and it was good to note that nursing staff felt well supported. It was positive to

note that members of staff who met with inspectors presented as motivated and enthusiastic and were complimentary regarding the support they received.

Staff stated:

“I am very positive about this ward”.

“I really enjoy working here”.

“The manager and staff are very helpful”.

“There is a vast range of patient need”.

“The ward is very busy”.

“My opinion is listened to and always considered”.

“As nurses we have to remain flexible and responsive”.

“I feel well supported”.

“If the team wasn’t as good as it is this would be a very difficult place to work”.

“I love working here”.

“The nursing care on the ward is very good and staff manage well”.

“The windows aren’t great and the older patients get very cold”.

“No two days are the same”.

The findings of this report will provide the service with the necessary information to enhance practice and service user experience.

4.1 Inspection Outcome

Total number of areas for improvement	Four

Findings of the inspection were discussed with the ward manager, members of the multi-disciplinary team and senior members of the trust as part of the inspection process and can be found in the main body of the report.

Escalation action did not result from the findings of this inspection.

5.0 How we Inspect

Prior to inspection we review a range of information relevant to the service. This included the following records:

- The operational policy for the ward.
- Incidents and accidents.
- Safeguarding vulnerable adults.
- Complaints.
- Health and safety assessments and associated action plans.
- Information in relation to governance, meetings, organisational management, structure and lines of accountability.
- Details of supervision and appraisal records.
- Policies and procedures.

During the inspection inspectors met with nine service users and 12 staff. No service users' visitors/representatives were available.

The following records were examined during the inspection:

- Care documentation in relation to four patients.
- Staff rota.
- Training records.
- Daily records.
- Accident and incident records.
- Patient medication charts.
- Patient information folder.
- Minutes of staff meetings.
- Minutes of patient meetings.
- Staff supervision timetable.
- Records and record keeping audit/ checklist.
- Weekly record of the inspection of means of escape.
- Weekly record of fire alarm checks.

During the inspection inspectors observed staff working practices and interactions with patients using a Quality of Interaction Schedule Tool (QUIS).

We reviewed the recommendations made at the last inspection. An assessment of compliance was recorded as four recommendations being met and one recommendation as being partially met.

The preliminary findings of the inspection were discussed at feedback to the service at the conclusion of the inspection.

6.0 The Inspection

The most recent inspection of Tobernaveen Centre was a follow up unannounced inspection. The completed Quality Improvement Plan (QIP) was returned and approved by the responsible inspectors. The QIP was validated by the inspectors during this inspection.

6.1 Review of Recommendations from Last Inspection dated 25 June 2015

Areas for Improvement		**Validation of Compliance**
The responsible person must ensure the following recommendations are addressed;		
Recommendation 1 **Ref**: Standard 5.3.1 (f) **Stated:** Second Time	It is recommended that the Ward Manager ensures that each section on the template for the MDT zoning meeting is completed in full.	**Met**
	Action taken as confirmed during the inspection: Inspectors reviewed four sets of patient care records including records of completed zoning meetings. Zoning meeting records had been completed in full. Where sections of zoning meetings had not been completed this corresponded with the list of attendees.	
Recommendation 2 **Ref**: Standard 5.3.1 (a) **Stated:** Second Time	It is recommended that the Ward Manager ensures that when staff complete the risk screening tool they complete this in accordance with the Promoting Quality Care (PQC) – Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services May 2010.	**Partially met**
	Action taken as confirmed during the inspection: Inspectors reviewed four risk screening tools. Inspectors evidenced that two risk assessments had not been completed in full. Sections relating to contingency planning and distributing lists had not been completed. Inspectors noted that this recommendation had been addressed to the Ward Manager. This is incorrect as each professional practitioner is accountable to ensuring that they complete the assessment in full. The recommendation will be	

	written to accurately reflect the requirements as outlined in the PQC 2010 guidance. Given these necessary changes to the original recommendation, this will be restated for the first time as an area for improvement in the provider compliance plan accompanying this report.	
Recommendation 3 **Ref**: Standard 5.3.1 (f) **Stated:** First Time	It is recommended that the Trust ensures that all patients on the ward receive a multi-disciplinary review of their care and treatment as per Trust policy and procedure. **Action taken as confirmed during the inspection**: Patient care records reviewed by inspectors evidenced that patients received a MDT review of their care and treatment on a weekly basis.	**Met**
Recommendation 4 **Ref**: Standard 6.3.1 (a) **Stated:** Second Time	It is recommended that the Trust reviews psychology input to the ward to ensure patients are receiving adequate support when an inpatient on the ward. **Action taken as confirmed during the inspection**: The Trust had appointed a Psychologist to work across all mental health acute admission wards. The Psychologist had protected time to work within Tobernaveen Centre. Staff who met with inspectors reported no concerns regarding their ability to access psychology support.	**Met**
Recommendation 5 **Ref**: Standard 5.3.3 (b) **Stated:** Second Time	It is recommendation 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. **Action taken as confirmed during the inspection**: Multi-disciplinary zoning records reviewed by inspectors evidenced that the outcome of meetings was discussed and shared with patients. Patient continuing care records also contained records of ongoing discussions with patients regarding MDT review meetings.	**Met**

7.0 Review of Findings

7.1 Is Care Safe?

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

Areas of Good Practice

The ward's environmental assessments were up to date.

Patients could access the appropriate range of professional staff.

The ward's safeguarding procedures were being managed in accordance to regional and Trust guidelines.

Patient risk assessments were individualised and up to date.

Staff were appropriately trained, motivated and enthusiastic.

Patients were involved in planning their care and treatment.

The ward had an effective working relationship with the Trust's estate services.

The ward promoted a least restrictive environment whilst encouraging positive risk taking.

Areas for Improvement

Inspectors were concerned that the ward presented with a number of risk factors including a large number of ligature points. The Trust has previously submitted a capital bid to construct a new purpose built mental health acute admission facility. Given the action already taken by the Trust this concern has been raised with the Department of Health and is not discussed in the ward's Provider Compliance Plan.

The ward's ligature risk management plan recorded that over 200 ligature points should be locally managed by nursing staff. The Trust should review this plan to reflect that staff can observe and monitor ligature risks as the expectation to locally manage all ligature risks is not possible.

The Trust should ensure that each of the acute care mental health wards within the Holywell Hospital site has an emergency resuscitation trolley/bag.

Number of areas for improvement	Two

7.2 Is Care Effective?

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

Areas of Good Practice

Patients' needs were comprehensively assessed.

The MDT worked well together and patients could access the full range of professionals.

The ward provided patients with a range of care and treatment options.

Nursing staff had a broad range of healthcare skills.

Care plans were noted to be patient centred, comprehensive and based on the assessed need of each patient.

The ward was clean and free from clutter.

The Ward Manager completed regular file audits.

MDT meetings were held regularly and all staff contributed.

Patient care records were maintained to a high standard.

Areas for Improvement

The Trust should ensure that the ethos and aim and objectives of the ward are clearly stated. This must include reference to care pathways for both patient groups for whom the ward provides care and treatment.

Number of areas for improvement	One

7.3 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.

Areas of Good Practice

Patients were complimentary about staff and the care and treatment provided on the ward.

Inspectors noted evidence of patient involvement in their care and treatment.

Patients reported feeling safe on the ward and staff were reported as being easy to talk to.

Patients' views were listened to and considered.

Staff and patient interactions observed by RQIA staff were informal, patient centred and effective.

The ward promoted a least restrictive practice environment.

Care records were evidenced as being individualised, comprehensive and up to date.

The ward was clean and staff made best use of the environment.

Areas for Improvement

There were no areas of concern in relation to compassionate care identified as a result of this inspection.

Number of areas for improvement	Nil

7.4 Is the Service Well Led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care

Areas of Good Practice

Staff reported that they received regular supervision, training and appraisal.

Staff had confidence in themselves, the team and the ward management.

Staff presented as motivated stating that they felt supported.

The ward implemented appropriate governance arrangements to support patient safety.

The ward staff had good effective working relationships with the Trust's safeguarding, estates and specialist teams.

Staff understood their role and responsibility within the Trust.

The ward's environment was continually reviewed and where possible changes were made.

The Ward Manager could access appropriately trained bank staff as and when required.

A new Consultant Psychiatrist to support those patients over the age of 65 had been appointed.

Areas for Improvement

There were no areas of concern in relation to well led care identified as a result of this inspection.

Number of areas for improvement	Nil

8.0 Provider Compliance Plan

Areas for improvement identified during this inspection are detailed in the provider compliance plan. Details of the provider compliance plan were discussed at feedback, as part of the inspection process. The timescales commence from the date of inspection

The responsible person should note that failure to comply with the findings of this inspection may lead to further /escalation action being taken. It is the responsibility of the responsible person to ensure that all areas identified for improvement within the provider compliance plan are addressed within the specified timescales.

8.1 Areas for Improvement

8.2 Actions to be taken by the Service

The provider compliance plan should be completed and detail the actions taken to meet the areas for improvement identified. The responsible person should confirm that these actions have been completed and return the completed provider compliance plan by 20 April 2017.

Provider Compliance Plan Tobernaveen Centre	
Priority 1	
The responsible person must ensure the following findings are addressed:	
Area for Improvement No. 1 **Ref: 5.3.1(a)** **Stated:** First time **To be completed by:** Ongoing basis.	All professional staff should ensure that they complete patient risk assessments in accordance to the required guidance and professional and Trust standards.
	Response by responsible person detailing the actions taken: Staff are aware of the importance of correct documentation when completing ICP's. Area addressed via group supervision and with full MDT.
Priority 2	
Area for Improvement No. 2 **Ref: 5.3.1(a)** **Stated:** First time **To be completed by:** 24 June 2017	The Trust should ensure that the ward's ligature risk assessment and associated action plan accurately reflects the role of ward staff in monitoring the large number of ligature points present within the ward's environment.
	Response by responsible person detailing the actions taken: Minor Works form completed and with Estates to treat potential ligature risk. The ward is currently undergoing major anti ligature estates work in respect to doors and windows. The expected date of completion is July 2017. An action plan has been developed to assist in managing the clinical environment and minimise further ligature risk. Antiligature Audit is completed annually on the ward.
	Priority 3
Area for Improvement No. 3 **Ref: 5.3.1(a)** **Stated: First time** **To be completed by: 24 September 2017**	The Trust should ensure that the ethos and aim and objectives of the ward are clearly stated. This must include reference to care pathways for both patient groups for whom the ward provides care and treatment.
	Response by responsible person detailing the actions taken: Two consultants aligned to the ward – one specifically for the care of the over 65 patient group with functional mental illness and one consultant for the under 65's with functional mental illness. The care pathway for both groups of patients follows the same journey. The Operational Policy for acute service reflects the care pathway for all ages over 18 years old. The acute admission units within Holywell have an overarching operational policy a working group has been set up to review and amend this policy to reflect the recent reorganisation of

	the ward to include both general adult and MHOP old age teams.
	Priority 4
Area for Improvement No. 4 **Ref: 5.3.1(f)** **Stated:** First time **To be completed by:** 24 September 2017	The Trust should ensure that all acute care mental health wards are equipped with an emergency resuscitation bag/trolley. **Response by responsible person detailing the actions taken:** An emergency response steering group has been established . The emergency response and training nurse is currently in process of acquiring emergency equipment for each ward.

Name of person(s) completing the provider compliance plan	DEIRDRE CONVERY		
Signature of person(s) completing the provider compliance plan	DEIRDRE CONVERY	**Date completed**	21/4/17
Name of responsible person approving the provider compliance plan	OSCAR DONNELLY		
Signature of responsible person approving the provider compliance plan	OSCAR DONNELLY	**Date approved**	21/4/17
Name of RQIA inspector assessing response	Alan Guthrie		
Signature of RQIA inspector assessing response	Alan Guthrie	**Date approved**	24/04/17

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