Unannounced Inspection Report
31 January 2019

Northern Health and Social Care Trust
Tobernaveen Centre

Holywell Hospital
60 Steeple Road
Antrim
BT41 2RJ
Tel No: 028 94413373

Inspectors: Cairn Magill, Thomas Hughes, Norma Munn and JudithTaylor

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

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 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 mixed gender ward. The ward provides assessment and treatment to patients with acute mental health needs over the age of 18, including the provision of 10 beds for patients with acute mental health needs over the age of 65.

On the day of the inspection there were 20 patients on the ward. Six patients were detained in accordance with the Mental Health (Northern Ireland) Order 1986 (The Order). The ward's multidisciplinary team (MDT) included psychiatry, medical, nursing, occupational therapy (OT), social work, psychology and pharmacy support. Patients had access to a physiotherapist and a speech and language therapy service by referral. A patient and carer advocacy service was also available for patients receiving care on the ward.

3.0 Service details

Responsible person: Dr Anthony Stevens, Chief Executive Officer Northern Health and Social Care Trust (NHSCT)	**Ward Manager:** Mrs Deirdre Convery
Category of care: Acute Mental Health	**Number of beds:** 20
Person in charge at the time of inspection: Moya Mc Gonigle, Deputy Ward Manager	

4.0 Inspection summary

An unannounced inspection took place on the 31 January 2019.

This inspection was undertaken by three care inspectors supported by a pharmacy inspector.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Mental Health (Northern Ireland) Order 1986 and The Quality Standards for Health and Social Care DHSSPSNI (March 2006).

This inspection was undertaken following concerns about patient care and treatment received from a patient who contacted RQIA. The concerns shared with RQIA related to:

- deprivation of liberty and restrictive practices;
- patient experiences (behaviours and attitude of staff);
- quality and availability of meals;
- management of patients' physical health care needs;
- infection prevention and control;
- medicines management.

While RQIA does not have formal powers to investigate complaints about health and social care services we take all concerns brought to our attention seriously.

Following concerns raised by a patient in another inpatient facility we sought to assess the arrangements in place when children visit the ward to ensure that the learning had been applied across the Trust's acute mental health inpatient facilities.

The following areas were examined during this inspection:

- management of restrictive practices;
- patient risk assessments and care plans;
- infection prevention and control arrangements;

- management of complaints and incidents;
- safeguarding referrals;
- medication records;
- staff training records;
- patient experience.

The previous Quality Improvement Plan (QIP) relating to this ward was also reviewed, to assess if the Trust had addressed areas of improvement identified during the most recent inspection of Tobernaveen Centre.

Inspectors visited the ward and reviewed the care and treatment processes. Inspectors evidenced the following outcomes:

Areas of good practice:

- Incidents were comprehensively documented in patients' care records;
- Care records reviewed contained appropriate assessments of patients' physical health care needs and there was evidence that appropriate and timely onward referral to other services had been made. The assessment outcomes were reflected in the patients' care plan;
- Restrictive practices required to support patient were being implemented in accordance with best practice guidance;
- Good communication and relationships between ward staff and patients were observed;
- The hospital's infection prevention and control team carried out regular, unannounced visits to the ward. The outcome of their most recent audit was good;
- There was evidence of largely satisfactory systems in place for medicines management.

Inspectors were concerned that:

- A safeguarding referral was delayed;
- Learning identified in another inpatient facility in the Trust, in respect of the arrangements for children visiting the ward had not been implemented;
- Expressions of dissatisfaction from patients were not recognised as informal complaints and were not well managed;
- In certain circumstances, staff may place themselves at risk of allegations being made against them;
- The monitoring system for the cold storage of medicines was not robust.

4.1 Inspection Outcome

Total number of areas for improvement	6

There are six new areas for improvement arising from this inspection. These are detailed in the QIP.

Details of the QIP were discussed with senior Trust representatives and members of the ward multi-disciplinary team as part of the inspection process. The timescales for implementation of these improvements commence from the date of inspection.

This inspection did not result in enforcement action.

5.0 How we inspect

Prior to this inspection a range of information relevant to the service was reviewed, including the following records:

- Previous inspection reports
- Serious Adverse Incident notifications
- Information on Concerns
- Information on Complaints
- Other relevant intelligence received by RQIA

Each ward is assessed using an inspection framework. The methodology underpinning our inspections include; discussion with patients and relatives, observation of practice; focus groups with staff and review of documentation. Records examined during the inspection include: nursing records, medical records, senior management and governance reports, safeguarding referrals, menu options and training records.

Areas for improvement identified at the previous care inspection were reviewed and an assessment of achievement was recorded as met, partially met, or not met.

Findings of this inspection were shared with senior Trust representatives and members of the ward multi-disciplinary team at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the previous inspection on 1 November 2018

The previous inspection of Tobernaveen Centre was an unannounced inspection undertaken on 1 November 2018.

The completed QIP was returned by the Trust to RQIA and was subsequently approved by the inspector.

6.2 Review of areas for improvement from the previous inspection on 1 November 2018

Areas for Improvement		Validation of Compliance
Area for Improvement No. 1 **Ref:** Standard 5.3.1 (a) **Stated:** Second Time **To be completed by:** 31 March 2019	All professional staff should ensure that they complete patient risk assessments in accordance to the required guidance and professional and Trust standards.	**Met**
	Action taken as confirmed during the inspection: This in is relation to patients who had a Comprehensive Risk Assessment (CRA) under Promoting Quality Care (PQC): Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability (2012). Inspectors evidenced that the Trust had clear procedures to ensure that CRA's were reviewed and updated in a timely manner by ward staff. In one patient record the risk assessment had not been completed in a timely manner this had been identified by ward staff who were engaging with the patient's key worker in the community to address this.	

Area for improvement 2 **Ref**: Standard 4.3 (h) **Stated:** First Time **To be completed by**: 31 March 2019	It is recommended that the Trust should ensure that a mechanism is put in place to ensure that the nearest relative is informed of their rights in accordance with Trust policy and procedure.	
	Action taken as confirmed during the inspection: Staff confirmed that the Trust's medical records department issue a letter simultaneously to patients and relatives via post. We reviewed the care records of three detained patients. Two of the three files recorded that the patient received their form 2 outlining their rights under the Mental Health NI Order 1986. We met with one patient who confirmed that they understood the reason for their detention, that their rights under the Mental Health NI Order 1986 were explained to them and they recalled receiving a leaflet outlining their rights. There were no relatives of detained patients available for discussion.	**Met**
Area for improvement 3 **Ref**: Standard 5.3.1 (a) **Stated:** First Time **To be completed by:** 31 March 2019	It is recommended that the Trust should ensure that risk assessments in relation to the use of a profiling bed are completed to reflect patients' overall assessment and risks from admission.	
	Action taken as confirmed during the inspection: On the day of the inspection no patients required a profiling bed. Staff were clear that profiling beds would only be used based on the patient's clinical need and that a maximum of two profiling beds were permitted on the ward at any time. We were satisfied that staff could effectively assess and manage risks in relation to profiling beds.	**Met**

Area for improvement 4 **Ref:** Standard 5.3.3 (f) **Stated:** First Time **To be completed by:** 1 May 2019	It is recommended that the Trust should ensure that patients over the age of 65 years who receive care on Tobernaveen Centre ward have access to a dedicated Occupational Therapy service	**Met**
	Action taken as confirmed during the inspection: An occupational therapist (OT) dedicated to the patients who are over 65 had recently been appointed and was in the process of planning a schedule of activities for this group of patients.	
Area for improvement 5 **Ref:** Standard 6.3.1 (a) **Stated:** First Time **To be completed by:** 1 May 2019	It is recommended that the Trust audit the care pathway system put in place four weeks prior to the last inspection (1 November 2018) to measure the effectiveness in relation to preventing inappropriate admissions to acute inpatient care.	**Met**
	Action taken as confirmed during the inspection: The Trust's Director of mental health, learning disability and community wellbeing wrote to us on 29 January 2019 advising that the Trust is developing an audit tool and are monitoring admissions. There have been no patients with a diagnosis of dementia admitted since October 2018.	
Area for improvement 6 **Ref:** Standard 6.3.1 (a) **Stated:** First Time **To be completed by:** 1 May 2019	It is recommended that a system is put in place to inform the Trust of the number of patients over the age of 65 years referred to CRHTT and also those patients who have been admitted to all acute inpatient assessment and treatment wards, including Tobernaveen Centre (TNC) ward.	**Met**
	Action taken as confirmed during the inspection: The Trust's Director of mental health, learning disability and community wellbeing wrote to us on 29 January 2019 advising that the Trust is in the process of developing a system to capture the data for patients over 65 who are referred to the Crisis Resolution Home Treatment Team and who are subsequently admitted to inpatient	

	assessment and treatment wards. The data collection will help inform the Trust for future service planning.	
Area for improvement 7 **Ref**: Standard 6.3.1 (a) **Stated:** First Time **To be completed by:** 30 November 2018	It is recommended that the Trust should ensure that patients who are assessed as requiring admission for care and treatment in Dementia Inpatient Care Unit (DICU) are not admitted to a ward which provides acute assessment and treatment to patients with a functional mental health needs.	**Met**
	Action taken as confirmed during the inspection: The Trust's Director of mental health, learning disability and community wellbeing wrote to us on 29 January 2019 advising that the Trust is monitoring the flow of patients with a diagnosis or potential diagnosis of dementia and confirmed that the Trust will facilitate admissions to the dementia care ward for these patients.	

6.3 Inspection findings

Deprivation of liberty and restrictive practices

Prior to this inspection we were contacted by a patient who expressed concerns to us in relation to restrictive practices and the deprivation of their liberty. The allegations centred around: preventing patients from leaving the ward; being supervised and monitored to the point where patients had no privacy; staff restricting patients from accessing and using their mobile phone and a lack of regard for patients' personal property and possessions prior to and during the period of admission.

Inspectors did not have the opportunity to speak directly with the patient whom these allegations related to, as the patient had been discharged. Inspectors spoke to staff and other patients around the general principles of deprivation of liberty and restrictive practices. Inspectors also reviewed relevant policies and procedures, care records of the patient who had expressed concerns to us prior to the inspection and patients currently on the ward where restrictive practices formed part of their care and treatment. Our review of the arrangements in place at ward level confirmed that restrictive practices were being managed in line with best practice.

On the morning of the inspection and throughout the duration of the inspection the front door to the ward was open and we observed patients entering and leaving the ward. We noted incidents when staff worked collaboratively with patients to encourage them to remain on the ward in line with both safeguarding and duty of care principles. Care records noted a range of

interventions that staff used to gain the patient's cooperation to ensure their well-being and safety.

We spoke with six patients who reported no concerns around deprivations of liberty or restrictive practices.

The ward's mobile phone policy was displayed in a prominent place in the foyer. During our review of patient care records we were satisfied that the grounds for implementing the mobile phone policy were met and we were satisfied staff clearly documented the decision making for implementing the policy.

Inspectors were satisfied that reasonable efforts were made to work with patients to safeguard their possessions.

During our inspection we noted that a staff member had visited a patients home to retrieve personal items, in an attempt to alleviate the patient's anxiety. Although well intended there was no evidence that this decision had been taken in line with the MDT. We were concerned that in doing so staff may leave themselves vulnerable. We discussed this with the deputy ward manager to ensure that any actions undertaken by staff do not place them at risk and are given prior agreement through the MDT process. An area of improvement has been made.

Patient experience

Prior to this inspection concerns were raised about the behaviours and attitudes of staff. We were informed that staff were sleeping on duty, treating patients in a 'bad way', withholding information from patients and that patient contact with consultant psychiatrists was sporadic and rare.

We spoke with patients and staff, reviewed patient care records and observed interactions between staff and patients. All patients who spoke with the inspectors reported a positive experience on the ward and good relationships with staff. Patients reported that they are well looked after, feel safe, that the ward is calm and is helping them in their recovery and that they had regular contact with their doctors.

In the care records reviewed, there was evidence that both of the consultant psychiatrists had a minimum of weekly contact with their patients during ward rounds and two junior doctors were present on the ward each day. An OT dedicated to patients over 65 years had recently commenced. OTs met with patients on an individual basis to draw up an individual time-table of activities. During the inspection, we observed group activities taking place and the OT staff advised that a new timetable of activities was being planned and will be displayed for patient's reference.

None of the patients spoken with raised staff sleeping on night duty as a concern. Senior members of the Trust's management team agreed to conduct unannounced night-time visits to each mental health inpatient ward and submit a report to RQIA of their findings by 1 March 2019. This report has not yet been received. We contacted the Trust's service manager who informed us that they had undertaken one unannounced night time visit with plans to undertake further unannounced night time visits over the remainder of 2019. An area for improvement has been made.

Quality and availability of meals

Prior to this inspection concerns were raised about a lack of choice and quality of food. As a result patients had to spend excessive amounts of money buying better quality food from the canteen.

Inspectors spoke with patients, ancillary staff and nursing staff and reviewed menu plans copies of patient menu choices for the following week. Patients are offered the opportunity at the beginning of each week to choose their meals for the remainder of the week. Menu options were varied and included a meat and vegetarian main meal option for lunch with a choice of two desserts. Menu choices were offered on a three week cycle basis. Staff reported that this system generally worked well. However, difficulties can arise when patients change their mind on the day the food arrives. Where possible, staff try to accommodate patient's wishes and note that each day one or two additional meals arrive to the ward. Dietary needs are recorded and special diets are accommodated.

Patients who spoke with inspectors were very complimentary about the quality of the food. A vending machine is also available for patient's to purchase alternative drinks and confectionary items.

Management of patients' physical health care needs

Prior to this inspection concerns were raised regarding the management of patients who present with specific health care needs.

We reviewed care records and spoke with patients and determined that patients' physical health care needs were comprehensively assessed. Appropriate risk assessments were completed such as a Malnutrition Universal Screening Tool (MUST), falls risk assessments and moving and handling risk assessments and these risk assessments were used to inform the patients' care plan. Patients were involved in care planning as was evidenced by their signatures. Care plans were being evaluated regularly alongside multi-disciplinary team meetings. There was timely onward referral to other specialists and diagnostic assessments such as referrals for CT scans; pain clinic, dietetics and allied health professionals, such as physiotherapy services. Input from specialist disciplines was well documented. Patient pain assessment scores were routinely documented on National Early Warning Score (NEWS) charts and patients with physical conditions stated that their care needs were being managed appropriately and they felt supported to manage their conditions.

Infection prevention and control

Prior to this inspection concerns were raised about the cleanliness and hygiene in specific areas of the ward. Inspectors spoke with patients, nursing staff and domestic staff, and assessed the ward environment and staff practices in line with the Regional Healthcare Hygiene and Cleanliness Standards. Inspectors found the ward was calm and welcoming and the environment was clean and uncluttered. The communal areas of the ward were generally well maintained. Appropriate infection control measures were in place for patients with active infections. The hospital's infection prevention and control team regularly visited the ward unannounced to complete audits such as: cleanliness, hand hygiene, commodes and good waste management. The ward scored high on audits conducted. These were displayed on the noticeboard.

One patient bay area was found to be of a lower standard; the fabric of the room; walls, floors and fixtures needed to be improved. Blood was found on the toilet tissue dispenser and the underside of toilet seat. The top side of the seat had faecal staining. The room was being cleaned once daily and spot checked in the evening, this was an insufficient level of monitoring to identify and address blood and bodily fluid exposure risks.

The ward manager and domestic staff agreed to enhance the frequency of cleaning to this area and to reallocate a patient with specific health care needs to another area. As a result of these immediate actions there were no areas of improvement made.

Medicines management

Prior to this inspection concerns were raised that patients were "comatose", sleeping for 24 hours, needed to be wakened up for food and that they were getting too much medication.

Inspectors reviewed patient's records including kardexes and case notes and found there was evidence of largely satisfactory systems in place for medicines management. There was regular pharmacy support to the ward, which included a review of prescribing and monitoring of stock levels. Kardexes and other medicines records were well maintained.

In instances where medicines were refused, this was followed up with the prescriber and dates for medicines prescribed at 72 hourly and weekly intervals were highlighted. In relation to medicines prescribed on a "when required" basis, there were clear parameters to direct the care of the patient. This included the indication for the medicine, the minimum frequency intervals and the maximum daily dose. A review of a sample of case notes clearly detailed the reason for and the outcome of any administration; we noted that these medicines were infrequently administered. Staff advised that the incidence of use was monitored and reviewed regularly as part of the medicine reviews. Of the records examined, there were no patients currently prescribed medicines for second line treatment. However, we did note that when this had been previously prescribed, details of first line and second line treatment were recorded.

Following discussion with patients, inspectors confirmed that they were involved in the decision making process regarding their medicines and medicines changes. Controlled drugs were stored and administered safely and records kept in line with Trust policy. Medicines were stored safely and securely and medicine areas were clean, tidy and well organised. Staff advised of the weekly stock review to ensure that the medicine trolley only contained medicines for current patients.

In relation to the cold storage of medicines, inspectors removed a number of medicines which must not be refrigerated, had expired or did not require refrigeration. Only the current refrigerator temperature was being recorded. An area for improvement has been made in relation to the cold storage of medicines.

Arrangements for children visiting the ward

Following concerns raised by a patient in another inpatient facility we sought to assess the arrangements in place when children visit the ward to ensure that the learning had been applied across the Trust's acute mental health inpatient facilities.

Staff confirmed that there are occasions when children visit patients on the ward and that some of these visits are accommodated in a lounge area at one end of the ward. To access this lounge area requires children to walk the entire length of the ward. We were concerned about the risk to children who during the course of their walk to the lounge may be exposed to distressed patients and the reduction in patient privacy. We discussed this with the senior Trust representatives and members of the ward multi-disciplinary team and asked that they review the current arrangements for children visiting the ward. An area for improvement has been made.

Further inspection findings

Safeguarding

Inspectors reviewed the arrangements in place for adult safeguarding. We examined care records, policies and procedures and spoke with staff and patients.

We reviewed care records and identified an incident where there was a delay in making an onward referral to adult safeguarding. We discussed this incident at length with the deputy ward manager, ward staff and the Designated Adult Protection Officer (DAPO). We were satisfied that despite the delay, an adult safeguarding referral was made within 24 hours and thereafter the correct procedures were followed and relevant people informed. We identified that the reason for the delay was that the staff member involved was unsure whether or not the incident they had observed had met the threshold for referral to adult safeguarding. As a result further training has been sought and provided to the staff. We are satisfied that management responded appropriately to this situation.

In light of our findings in respect of a delay in making an onward referral to adult safeguarding and having regard to our discussions with staff on the arrangements for children visiting the ward we explored staff's knowledge further. We examined staff training records and noted the majority of staff had up-to-date Children's and Adult's safeguarding training. During our discussion with staff we were informed that staff would refer to the Trust's safeguarding policies. On enquiry staff were unable to locate the Trust's safeguarding policy and procedure either in hardcopy or on the Trust's intranet. The only reference available to guide staff was the Department of Health Adult Safeguarding: Prevention and Protection in Partnership policy document. Staff could not show us the correct referral form to use. We are concerned that staff's knowledge of safeguarding was not embedded in practice and staff had no up-to-date Trust policy or procedure to refer to. An area for improvement has been made.

Complaints management

As part of our inspection we asked to review the ward's record of complaints. Staff informed us that all complaints were directed through the Trust's central complaints office as outlined in the Trust's complaint's policy. There was no mechanism at ward level to record expressions of dissatisfaction or complaints of an informal nature. As a result staff at ward level are unable to capture this data and make the necessary improvements based on patterns or trends which may emerge as a result. The importance of retaining a record of expressions of dissatisfaction or informal complaints was discussed with the deputy ward manager and an area of improvement has been made.

Total number of areas for improvement	6

7.0 Quality Improvement Plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with senior Trust representatives and members of the ward multi-disciplinary team as part of the inspection process. The timescales for implementation of these improvements commence from the date of this inspection.

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

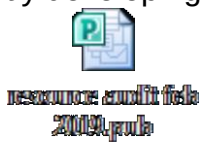
7.1 Areas for improvement

Areas for improvement have been identified in which action is required to ensure compliance with The Mental Health (Northern Ireland) Order 1986 and The Quality Standards for Health and Social Care DHSSPSNI (March 2006).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to meet the areas for improvement identified. The Trust should confirm that these actions have been completed and return the completed QIP to MHLD.Programme@rqia.org.uk for assessment by the inspector by **10 December 2019.**

Quality Improvement Plan	
The Trust must ensure the following findings are addressed:	
Area for Improvement No. 1 **Ref:** Standard 5.3.1 (f) **Stated:** First Time **To be completed by** 31 May 2019	The Trust's senior management team must:: Ensure staff's knowledge and training in respect of safeguarding is embedded into practice. Ensure that up-to-date safeguarding policies and procedures are easily accessible for staff.
	Response by the Trust detailing the actions taken: The Trust has a Safeguarding Policy which is held within the Trust Policy Library available for all staff via Staffnet. It outlines what is meant by safeguarding and the roles of staff when an alert is raised in relation to an adult safeguarding concern or disclosure. In addition a number of resources are available at ward level which is easily accessible for staff (see attached). As part of mandatory training, ward staff are required to attend Safeguarding training every three years. Each ward has a training matrix which records training

	undertaken by each staff member. On the 12/11/19 a learning event known as an 'Academic Afternoon' was held which focused specifically on Adult Safeguarding and Joint Protocol. Reflective Practice sessions are currently being piloted in Tobernaveen Lower every six weeks. Management will review pilot and consider its further roll out to other wards. Initial feedback is positive. Zoning meetings at ward level discuss safeguarding concerns and these are recorded and held at ward level. On Tobernaveen Centre a meeting is held at 2pm daily to discuss any issues, incidents or actions which can include safeguarding. The Trust Safeguarding lead is currently developing a user friendly  Safeguarding flowchart for each ward.

Area for Improvement No. 2 **Ref:** Standard 5.3.1. **Stated:** First Time **To be completed by**: 31 May 2019	The Trust's senior management team need to assure themselves that all staff know how to facilitate, manage and risk assess children visiting the wards. Each ward should have its own procedure outlining how they can facilitate these visits taking cognisance of room availability, proximity to the exit, protecting visitors from witnessing patients in distress, patient needs and staffing ratios.
	Response by the Trust detailing the actions taken: The Trust has developed a policy regarding children visiting the wards – 'Children Visiting an Adult Mental Health Ward Policy and Procedure NHSCT/19/1285'. The Policy highlights that visits by children to Mental Health Wards should only take place in accordance with the patient's written care plan and should be on a planned and agreed basis. Local ward procedures are currently in development. Good practice recommends that psychiatric wards should provide an area that can facilitate child visits away from the main body of the ward. Within the Tobernaveen wards there is not a dedicated room for children visiting and some rooms double up to provide this provision. Within Tobernaveen Centre, the room allocated for children visiting is also used as an Occupational Therapy room for the over 65 service users. When required the room is in close proximity to the exit away from the main body of the hospital. Patients and relatives are informed of the need to book ahead of time when facilitating children visiting the ward. This is regularly discussed and reviewed at both the patient staff meetings as well as the ward business meetings.
Area for Improvement No. 3 **Ref:** Standard 5.3.2 (c) & (d) **Stated:** First Time **To be completed by:** 31 May 2019	The Trust must implement a mechanism to record expressions of dissatisfaction or informal complaints at ward level. The record should note the name of the complainant, the nature of the complaint, the action taken to resolve the matter including any actions taken to prevent a similar issue arising and whether or not the complainant was satisfied with the response. This information should be used by the Trust to drive improvements based on patterns or trends which may emerge.
	Response by the Trust detailing the actions taken: A book is now currently being used, which addresses any dissatisfaction or complaints at ward level, and the actions staff took to resolve the issue. These matters are discussed at the ward Business Meetings, which are held monthly as well as the ward patient/staff meetings which at present take place once every month. In addition complaints are reviewed at the Seniors Meeting weekly. This meeting is attended by Ward Managers, Nursing Services Managers and the Head of Acute Services. It provides an opportunity to review complaints and identify themes and trends. Complaints are also reviewed quarterly at the Acute Care Forum and

	also at the Divisional Governance Meeting. This provides an opportunity to discuss complaints, identify themes and areas for improvement.
Area for Improvement No. 4 **Ref:** Standard 5.3.1.(f) **Stated:** First Time **To be completed by:** 31 May 2019	The Trust must ensure that staff do not place themselves in circumstances were they may be at risk of allegations being made against them, even when their actions are well intended. Such circumstances must always be discussed during MDT meetings and prior agreement be given.
	Response by the Trust detailing the actions taken: If and when a service user may require personal belongings from their home address, this is discussed at the MDT meeting and agreement is given through the MDT. This is to ensure that all potential risks have been considered.
Area for Improvement No. 5 **Ref:** Standard 5.3.1 (f) **Stated:** First Time **To be completed by:** 31 May 2019	The Trust should implement a robust monitoring system for the cold storage of medicines; to ensure that the minimum and maximum medicine refrigerator temperatures are recorded, the thermometer is reset every day and medicines are stored in accordance with the manufacturers' instructions.
	Response by the Trust detailing the actions taken: There is now a new thermometer installed and the recording of the temperatures is allocated daily to staff. This is discussed at the Daily handover at the beginning of the shift. Staff also clean out the refrigerator weekly and remove any medicines that should not be stored in the refrigerator.

Area for Improvement No. 6 **Ref:** Standard 5.3.3 **Stated:** First Time **To be completed by:** 31 December 2019	The Trust should submit a report to RQIA evidencing the outcomes from their series of unannounced night-time visits. This report should provide assurances to the Trust that staff are not sleeping on night duty and that there is adequate care and treatment being provided to patients during the night.
	Response by the Trust detailing the actions taken: The Nursing Coordinator (Band 7) is the most senior member of staff on duty during the night. The Nursing Coordinator provides a variety of roles one which includes a series of walks at night across the wards to ensure wards are safe, adequately staffed and that staff are fulfilling their duties. Any issues are recorded on the 24 hr report that is then sent to all senior managers the following morning at 7:30am. The Nursing Services Managers (8a) also conduct a number of out of hours visits to particularly meet with staff who work night duty only. In addition the Trust Senior Management Team (Divisional Director and Interim Head of Service) scheduled and conducted night time visits to the wards with the first visit being conducted on the 26th of February 2019 to the Ross Thomson Unit (RTU) and a further visit to the wards in the Holywell site was conducted by Interim Head of service on the 2nd September 2019, wards visited included Tobernaveen Lower, Lissan 1 and Tobernaveen Upper. Both visits were undertaken shortly after 10pm. In the first visit to RTU, on arrival, management were able to observe the team on shift engaging with patients while others in the team were conducting assigned tasks as per the duty allocation. The visiting team spent a significant amount of time on the ward engaging with both staff and patients while also conducting a walk through the unit. Staff were able to highlight a few outstanding estates issues that senior management were able to chase through the following day. Staff also fed back on some of the tasks at night which included reviewing care management plans as well as risk assessment, preparing reports for zoning meetings, but also conducting ward based audits and partaking in admission processes as most admissions to the ward occur after hours. The visiting team was satisfied that adequate care and treatment was evident on this occasion. The Holywell visit by the interim Head of service on the 2nd of September 2019 undertook a similar approach, in which discussions with staff and patients still awake revealed general satisfaction among the patients and staff alike. The Senior Management Team remains committed to visiting wards out of hours and the benefits of speaking with both staff and patients and reviewing practice. A further schedule of night visits by the

	Senior Management Team is planned throughout 2020/21.

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

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